Royal Sundaram General Insurance Co. Limited
Corp. Office : Vishranthi Melaram Towers, No. 2 / 319,
Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097.
Regd. Office : 21, Patullos Road, Chennai - 600 002

Part II- Policy Document

Policy Terms and Conditions

B Preamble

The insurance cover provided under this Policy to the Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium, and (c) Disclosure to Information Norm (including by way of the Proposal or Information Summary Sheet) for Yourself and on behalf of all persons to be insured. Please inform Us immediately of any change in the address, nature of job, state of health, or of any other changes affecting You or any Insured Person.

If any claim arising as a result of an Illness or Injury that occurred during the Policy Period becomes payable, then we shall pay the benefits in accordance with terms, and exclusions of the Policy over and above the deductible amount subject to availability of Sum Insured.

C Definitions

The terms defined below and at other junctures in the policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

C.1 Standard Definitions

C.1.1 **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

C.1.2 An **AYUSH Hospital** is a health care facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a) Central or State Government AYUSH Hospital or
b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
    I. Having at least 5 in-patient beds;
    II. Having qualified AYUSH Medical Practitioner in charge round the clock;
    III. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    IV. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

C.1.3 **AYUSH Day Care Centre** means and includes Community Health Care (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment registered AYUSH Medical Practioner (s) on day care basis without in-patient services and must comply with all the following criteria:

i. Having qualified registered A YUSH Medical Practitioner(s) in charge;
ii. Having dedicated A YUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

C.1.4 **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

C.1.5 **Break in policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

C.1.6 **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

C.1.7 **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

C.1.8 **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) **Internal Congenital Anomaly**

Congenital anomaly which is not in the visible and accessible parts of the body.

b) **External Congenital Anomaly**

Congenital anomaly which is in the visible and accessible parts of the body.

C.1.9 **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 claims amount. A co-payment does not reduce the Sum Insured.

C.1.10 **Critical Illness** means the following:

C.1.10.1 CANCER OF SPECIFIED SEVERITY

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not

limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3.

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

C.1.10.2 MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

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

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

C.1.10.3 OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:
   i. Angioplasty and/or any other intra-arterial procedures

C.1.10.4 OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

C.1.10.5 COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

C.1.10.6 KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

C.1.10.7 STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   i. Transient ischemic attacks (TIA)
   ii. Traumatic injury of the brain
   iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

C.1.10.8 MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:
   i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:
   i. Other stem-cell transplants
   ii. Where only islets of langerhans are transplanted

C.1.10.9 PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

C.1.10.10MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

C.1.10.11MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE are excluded.

C.1.10.12ANGIOPLASTY

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

C.1.10.13BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
   i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
   ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded: Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

C.1.10.14BLINDNESS

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:
   i. corrected visual acuity being 3/60 or less in both eyes or ;
   ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

C.1.10.15DEAFNESS

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing” in both ears.

C.1.10.16END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
iv. Dyspnea at rest.

C.1.10.17END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following: Permanent jaundice; and Ascites; and Hepatic encephalopathy.
II. Liver failure secondary to drug or alcohol abuse is excluded.

C.1.10.18LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.
II. All psychiatric related causes are excluded.

C.1.10.19LOSS OF LIMBS

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

C.1.10.20MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.
III. The Activities of Daily Living are:
    i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
    ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
    iv. Mobility: the ability to move indoors from room to room on level surfaces;
    v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    vi. Feeding: the ability to feed oneself once food has been prepared and made available.
IV. The following are excluded: i. Spinal cord injury;

C.1.10.21PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows: i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms. ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

C.1.10.22THIRD DEGREE BURNS

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area

C.1.11 Day Care Centre means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under.

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner (s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

C.1.12 Day Care Treatment means medical treatment, and/or surgical procedure which is:

i. Undertaken under general or local anaesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and
ii. Which would have otherwise required a hospitalization of more than twenty four hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

C.1.13 Deductible:

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. The deductible will apply on aggregate of all admissible claims under the policy per annum on an Individual/Family Floater policy basis and for exhaustion of deductible, we will consider Hospitalizations in India only.

C.1.14 Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

C.1.15 Disclosure to information norm: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

C.1.16 Domiciliary Hospitalization

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

C.1.17 Emergency Care:

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.

C.1.18 Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

C.1.19 Hospital means any institution established for in-patient care and day care treatment of disease/ 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 Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

C.1.20 Hospitalization means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

C.1.21 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** means a disease, illness or injury that is likely to response 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** means 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-rips, and / or tests
b) It needs ongoing or long-terns control or relief of symptoms
c) It requires rehabilitation for the patient or for the patient to be special trained to cope with it
d) It continues indefinitely
e) It recurs or is likely to recur

C.1.22 **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.

C.1.23 **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

C.1.24 **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.

C.1.25 **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensives charges.

C.1.26 **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

C.1.27 **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.

C.1.28 **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 the licence.

C.1.29 **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 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.

C.1.30 Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

C.1.31 Network Provider means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cash less facility.

C.1.32 Non- Network Provider means any hospital that is not part of the network.

C.1.33 Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

C.1.34 Out-Patient (OPD) Treatment means treatment in which the insured visits a clinic/ hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.

C.1.35 Pre-Existing Disease (PED): "Pre-existing disease (PED)" means any condition, ailment, injury or disease:
a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

C.1.36 Pre-hospitalization Medical Expenses

Medical Expenses incurred immediately before the Insured Person is Hospitalized, provided that:

I. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required and;
II. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

C.1.37 Post-hospitalization Medical Expenses

Medical Expenses incurred immediately after the Insured Person is discharged from the hospital, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required and;
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

C.1.38 Portability
"Portability" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

C.1.39 Qualified Nurse
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.

C.1.40 Reasonable and Customary Charges

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

C.1.41 Renewal

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.

C.1.42 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

C.1.43 "**Specific waiting period**" means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

C.1.44 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 and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

C.1.45 Unproven/Experimental treatment:

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.

C.2 Specific Definitions

C.2.1 Accidental means sudden, unforeseen and involuntary event caused by external, visible and violent means.

C.2.2 Alternative Treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

C.2.3 Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date.

C.2.4 Diagnostic Tests: Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

C.2.5 Emergency means a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

C.2.6 Family Floater Policy means a Policy in terms of which, two or more persons of a Family are named in the Schedule of Insurance Certificate as Insured Persons. In a Family Floater Policy, Family means a unit comprising of upto six members who are related to each other in the following manner:

i) Legally married husband and wife as long as they continue to be married; and/or

ii) Up-to four of their children who are less than 25 years on the date of commencement of the cover under the Policy.

C.2.7 **Hospitalized** means the admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

C.2.8 **Individual Policy** means a Policy in terms of which only one person is named in the Schedule of Insurance Certificate as Insured Person.

C.2.9 **Information Summary Sheet** means the record and confirmation of information provided to Us or Our representatives over the telephone for the purposes of applying for this Policy.

C.2.10 **Inpatient** means the Insured Person's admission to for treatment in a Hospital for more than 24 hours for a covered event.

C.2.11 **Insured Person** means person named as insured in the Schedule of Insurance Certificate. Any Family member may be added as an Insured Person during the Policy Period if We have accepted his application for insurance and issued an endorsement confirming the addition of such person as an Insured Person.

C.2.12 **Life Threatening Condition** means a medical condition which if not treated by instant hospitalization under a qualified doctor can lead to immediate threat to human life.

- Life Threatening Condition should be certified by the treating physician in the hospital and should be clearly mentioned in hospital admission summary or case summary.
- Life Threatening Condition involves adverse situation of few vital parameters such as severe difficulty in breathing, severe dehydration, imbalanced ammonia levels in the body, impaired pulse rate, heart stroke, low platelets levels, internal bleeding, profuse external bleeding, very high bilirubin levels etc.

C.2.13 **Policy** means these terms and conditions, any annexure thereto and the Schedule of Insurance Certificate (as amended from time to time), Your statements in the proposal form and the Information Summary Sheet and the policy wording (including endorsements, if any).

C.2.14 **Policy Period** means the period between the date of commencement and the expiry date specified shown in the Schedule of Insurance Certificate.

C.2.15 **Policy Year** means the period of one year commencing on the date of commencement specified in the Schedule of Insurance Certificate or any anniversary thereof.

C.2.16 **Product Benefits Table** means the Product Benefits Table issued by Us and accompanying this Policy and annexures thereto.

C.2.17 **Rehabilitation**: Treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.

C.2.18 **Schedule of Insurance Certificate** means the schedule provided in the insurance certificate issued by Us, and, if more than one, then the latest in time.

C.2.19 **Sum Insured** means the sum shown in the Schedule of Insurance Certificate which represents Our maximum total and cumulative liability for any and all claims under the Policy during the Policy Year.

C.2.20 **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

C.2.21 **We/Our/Us** means Royal Sundaram General Insurance Co. Limited.

C.2.22 **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously relieved without any break.

C.2.23 **You/Your/Policyholder** means the person named in the Schedule of Insurance Certificate who has concluded this Policy with Us.

Any reference to any statute shall be deemed to refer to any replacement or amendment to that statute.

D Benefits Covered Under the Policy

The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken during the Policy Period for an Illness, Accident or condition described below if this is contracted or sustained by an Insured Person during the Policy Period and subject always to the Sum Insured, any sub limit specified in the Product Benefits Table, the terms, conditions, limitations and exclusions mentioned in the Policy. Claim under this Policy will be payable only after exhaustion of Deductible amount as opted by the insured in the policy and as specified in the policy schedule and for exhaustion of deductible opted under this Policy, terms and conditions of this Policy will be considered.

Base Covers

D.1 Inpatient Care

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured specified in the policy schedule, for

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital
iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

D.2 Modern Treatments

The following procedures will be covered (whichever medically indicated) either as in patient or as part of day care treatment in a hospital up to Sum Insured as specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy - Monoclonal Antibody to be given as injection
F. Intra vitreal injection
G. Robotic surgeries

H. Stereotactic radio surgeries
I. Bronchical Thermoplastic
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

D.3 Pre-hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days prior to the date of admissible hospitalization covered under the policy.

D.4 Post-hospitalization

The company shall indemnify Post-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 90 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

D.5 Day Care Treatment

We will cover Medical Expenses of an Insured Person up to Sum Insured in case of any Medically Necessary Day Care Treatment or Surgery that require less than 24 hours Hospitalization due to advancement in technology and which is undertaken in a Hospital/Day Care Centre on the recommendation of a Medical Practitioner. Any OPD Treatment undertaken in a Hospital/Day Care Centre will not be covered. Pre and Post-Hospitalization Medical Expenses are payable up to 30 days under this benefit.

D.6 Organ Donor Expenses

We will cover Inpatient Care Medical Expenses towards the donor for the harvesting of the organ donated provided that:

(a) the organ donor is any person in accordance with the Transplantation of Human Organs Act, 1994 and other applicable laws.
(b) the organ donated is for the use of the Insured Person who has been asked to undergo an organ transplantation on Medical Advice;
(c) We have admitted a claim under Section D.1 towards Inpatient Care. Organ donor expenses will be covered within the sum insured for the patient who is insured with us i.e. recipient of the Organ (who is undergoing the transplant)

We will not cover:

(a) Pre-hospitalization or Post-Hospitalization Medical Expenses or screening expenses of the donor or any other Medical Expenses as a result of the harvesting from the donor;
(b) Costs directly or indirectly associated with the acquisition of the donor's organ;
(c) Any other medical treatment or complication in respect of donor, consequent to harvesting.

D.7 Domiciliary Hospitalization

We will cover Medical Expenses up to Sum Insured for medical treatment taken at home if this continues for an uninterrupted period of 3 days and the condition for which treatment is taken would otherwise have necessitated Hospitalization as long as either

(i) the attending Medical Practitioner confirms that the Insured Person could not be transferred to a Hospital or
(ii) the Insured Person satisfies Us that a Hospital bed was unavailable.

If a claim has been accepted under this Benefit, the claims for Pre and Post-Hospitalization Medical Expenses are payable up to 30 days under this benefit.

D.8 AYUSH Treatment

Expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines is covered up to 100% of Sum Insured, during each policy year as specified in the policy schedule.

D.9 Ambulance Cover including App-based Cab cover

We will cover Reasonable and Customary Charges for ambulance expenses that are incurred towards transportation of an Insured Person by surface transport following an Emergency to the nearest Hospital with adequate facilities.

We will also cover charges for app based cabs service incurred towards transportation of an Insured Person at the time of getting admitted to the Hospital.

This benefit is available only on reimbursement basis on the basis of submission of an invoice generated by a digital app based cab service and the invoice must mention following details

i. Date,
ii. Location of pick-up and drop,
iii. Time of pick-up and drop.

These charges are payable only if we have accepted a Hospitalization claim under the provisions of Section D.1 above. Benefit under this cover is payable maximum up to the limits specified in Product Benefits Table and any claim under this section will reduce the Sum Insured.

D.10 Second Opinion for Critical Illness

We will provide You a second opinion from Medical Practitioner, if an Insured Person is diagnosed with the Critical Illness during the Policy Period. The expert opinion would be directly sent to the Insured Person.

You understand and agree that You can exercise the option to secure a second opinion, provided:

i. We have received a request from You to exercise this option;
ii. The second opinion will be based only on the information and documentation provided by the Insured Person that will be shared with the Medical Practitioner;
iii. This benefit can be availed once by an Insured Person during a Policy Year and once during the lifetime of an Insured Person for the same illness;
iv. This benefit shall be available only to those Insured Persons that are age 18 years or above on the Policy Period Start Date provided further that this benefit shall not be

available to those Insured Person who is covered under the Policy as the Policyholder's child;

v. This benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner;

vi. The Insured Person is free to choose whether or not to obtain the second opinion, and if obtained then whether or not to act on it;

vii. We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any second opinion or for any consequence of actions taken or not taken in reliance thereon;

viii. The second opinion under this Policy shall be limited to covered Critical Illnesses and not be valid for any medical legal purposes;

ix. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by Medical Practitioner;

x. For the purpose of this benefit covered Critical Illness shall include:

1. Cancer of Specified Severity
2. First Heart Attack of Specified Severity
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure requiring Regular Dialysis
7. Stroke resulting in Permanent Symptoms
8. Major Organ/Bone Marrow Transplant
9. Permanent paralysis of Limbs
10. Motor Neurone Disease with Permanent Symptoms
11. Multiple Sclerosis with Persisting Symptoms
12. Angioplasty
13. Benign brain Tumor
14. Blindness
15. Deafness
16. End stage lung Failure
17. End stage liver failure
18. Loss of speech
19. Loss of limbs
20. Major head trauma
21. Primary (idiopathic) pulmonary hypertension
22. Third degree burns

D.11 Home Care Treatment

We shall cover the treatment expenses up to the limits as specified in the Policy Schedule/ Product Benefit Table of this Policy for the Insured Person's treatment at his/her home in case of pandemic/endemic/ any other exceptional circumstances

(i) This benefit is available on Reimbursement basis only subject to prior intimation and approval from Us.

(ii) The limit under this benefit as specified in the Product Benefit Table is applicable Per event of Home Care Treatment and per insured person per policy year.

(iii) OPD Treatment is not covered under this Benefit.

(iv) The amount, frequency and time period of the home care treatment services should be reasonable and supported in agreement by the treating Medical Practitioner and the Insured Person availing the service.

(v) The condition of the Insured Person must be expected to improve in a reasonable and generally predictable period of time.

(vi) Treatment under this Benefit should be availed under the supervision of a Medical Practitioner to safely and effectively administer the home treatment plan, in accordance with the condition of the Insured Person.

D.12 Life Protect Benefit

In the event of Life Threatening Condition if the Sum Insured becomes insufficient, we will give additional amount for any claim admissible under section D.1 up to the limits specified in Product Benefits Table

i. This benefit is available only in the event of Life Threatening condition.
ii. Certification by the treating Medical Practitioner of such life threatening emergency condition is necessary.
iii. Our maximum liability will be limited to the limits specified in Product Benefits Table
iv. Once triggered, any unutilized amount with respect to this benefit will not be carried forward.
v. This benefit is over and above the Sum Insured and utilization of this benefit will not reduce the Sum Insured.
vi. This benefit will be triggered in case of Life Threatening Condition irrespective of exhaustion of Sum Insured under this Policy.

Optional Cover

D.13 Reduction in Pre Existing Disease waiting period

If this cover is opted the Pre-existing disease waiting period in the policy will be reduced from 36 Months to 24 Months and under section E.1.1 of Policy Wordings the term '36 months' shall be replaced with '24 months'.

E Exclusions

E.1 Standard Exclusions

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

E.1.1 Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) lf the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

E.1.2 30 Days Waiting Period (Code- Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an

Accident, provided the same are covered.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

E.1.3 Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. The exclusion shall not be applicable for claims arising due to an Accident.

b) ln case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures is as under:

a) Cataract
b) Stones in biliary and urinary systems
c) Hernia / Hydrocele
d) Hysterectomy for any benign disorder
e) Lumps / cysts / nodules / polyps / internal tumours
f) Gastric and Duodenal Ulcers
g) Surgery on tonsils / adenoids
h) Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
i) Fissure / Fistula / Haemorrhoid
j) Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
k) Benign Prostatic Hypertrophy
l) Knee/Hip Joint replacement
m) Dilatation and Curettage
n) Varicose veins
o) Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
p) Chronic Renal Failure or end stage Renal Failure or Chronic liver failure

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

E.1.4 Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

E.1.5 Rest Cure, rehabilitation and respite care (Code- ExcI05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

E.1.6 Obesity/ Weight Control (Code- ExcI06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

E.1.7 Change-of-Gender treatments: (Code- Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body of those of the opposite sex.

E.1.8 Cosmetic or plastic Surgery: (Code- Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

E.1.9 Hazardous or Adventure sports: (Code- ExcI09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

E.1.10 Breach of law: (Code- Excl10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

E.1.11 Excluded Providers: (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded but the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threating situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

E.1.12 Treatment for, Alcoholism, drug or substance abuse, Tobacco abuse or any addictive condition and consequences thereof.**(Code- Excl12)**

E.1.13 Treatments received in health hydro's, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

E.1.14 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.**(Code- Excl14)**

E.1.15 Refractive Error.- (Code- Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

E.1.16 Unproven Treatments:**(Code- Excl16)**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

E.1.17 Sterility and Infertility: **(Code- Excl17)**
Expenses related to sterility and infertility. This includes:

- **i.** Any type of contraception, sterilization
- **ii.** Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- **iii.** Gestational Surrogacy
- **iv.** Reversal of sterilization

E.1.18 Maternity Expenses (Code – Excl18):

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

E.2 Specific Exclusions

E.2.1 Personal Waiting Periods

A special waiting period not exceeding 36 months, may be applied to Individual Insured Persons depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule of Insurance Certificate and will be applied only after receiving Your specific consent. Personal Waiting Period may be applied in case of Portability only basis the Underwriting.

E.2.2 Alternative treatment

Any Alternative Treatment except for the benefits under Section D.8 (AYUSH Treatment)

E.2.3 Circumcision

Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

E.2.4 Conflict and disaster

Treatment for any illness or injury resulting from nuclear or chemical contamination, war, riot, revolution, acts of terrorism or any similar event (other than natural disaster or calamity), if one or more of the following conditions apply:

a. The Insured Person put himself in danger by entering a known area of conflict where active fighting or insurrections are taking place

b. The Insured Person was an active participant in the above mentioned acts or events of a similar nature.

c. The Insured Person displayed a blatant disregard for personal safety

E.2.5 Congenital conditions

Treatment for any External Congenital Anomaly.

E.2.6 Convalescence and Rehabilitation

Hospital accommodation when it is used solely or primarily for any of the following purposes:

a. Convalescence, rehabilitation, supervision or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in Hospital.

b. receiving general nursing care or any other services that do not require the Insured Person to be in Hospital and could be provided in another establishment that is not a Hospital

c. receiving services from a therapist or complementary medical practitioner or a practitioner of Alternative Treatment.

E.2.7 Drugs and dressings for OPD Treatment or take-home use

Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment, or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-hospitalization expenses under Section D.4 above.

E.2.8 Items of personal comfort and convenience, including but not limited to:

A. Telephone, television, diet charges, (unless included in room rent) personal attendant or barber or beauty services, baby food, cosmetics, napkins, toiletry items, guest services and similar incidental expenses or services.
B. Private nursing/attendant's charges incurred during Pre-hospitalization or Post-hospitalization.
C. Drugs or treatment not supported by prescription.
D. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.
E. Any charges incurred to procure any treatment/Illness related documents pertaining to any period of Hospitalization/Illness.
F. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer/thermometer and similar items and also any medical equipment which is subsequently used at home.

E.2.9 OPD treatment

Any expenses incurred on OPD treatment.

E.2.10 Preventive Care

All preventive care, vaccination including inoculation and immunisations.

E.2.11 Self-inflicted injuries

Treatment for, or arising from, an injury that is intentionally self-inflicted, including attempted suicide.

E.2.12 Treatment for Alopecia

Any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

E.2.13 Treatments taken outside the geographical limits of India.

E.2.14 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

E.2.15 Ancillary Hospital Charges - Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, night charges, registration, documentation and filing, surcharges. Service charges levied by the Hospital under whatever head.

E.2.16 Charges for medical papers

Any charges incurred to procure any medical certificate, medical records, treatment or Illness/Injury related documents pertaining to any period of Hospitalization/Day Care Treatment undertaken for any Accident, Illness or Injury.

E.2.17 Dental/oral treatment

Dental treatment including Surgical Procedures for the treatment of bone disease when related to gum disease or damage, or treatment for, or treatment arising from, disorders of the tempromandibular joint.

EXCEPTION: We will pay for a Surgical Procedure for which the Insured Person is Hospitalized as a result of an Accident and which is undertaken for Inpatient Care in a Hospital and carried out by a Medical Practitioner.

E.2.18 Artificial Life maintenance is not covered from the time Insured Person goes into vegetative state and a point of no recovery to Life.

E.2.19 The expenses that are not covered in this policy are placed under List-I of Annexure-A.

F General Terms & Clauses

F.1 Standard General Terms and Clauses

F.1.1 Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

F.1.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

F.1.3 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 15 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 15 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 15 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

F.1.4 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the company to the extent of that amount for the particular claim

F.1.5 Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Policy holder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy after, the Policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

F.1.6 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:—

a) the suggestion ,as a fact of that which is not true and which the Insured Person does not believe to be true;
b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer. Onus or disproving is upon the policyholder, if alive, or beneficiaries.

F.1.7 Cancellation

The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing.

The Company shall:

a. refund proportionate premium for unexpired policy period, if the term of policy is up to one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

The Company may cancel the Policy at any time on grounds of misrepresentative, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

F.1.8 Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section E shall be reduced by the number

of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.

ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), migration benefits shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the below link:-

https://www.royalsundaram.in/html/files/Modification-guidelines-on-standardization-in-health-insurance-Migration.pdf

F.1.9 Portability

The insured Person will have the option to port the policy to other insurers as an extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section E shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the below link:- https://www.royalsundaram.in/health-insurance/health-insurance-portability

F.1.10 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due to renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
v. If not renewed within Grace Period after due renewal date, the Policy shall terminate.
vi. No loading shall apply on renewals based on individual claims experience.

F.1.11 Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

F.1.12 Moratorium Period

After completion of five continuous years under this policy no look back would be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the Sum Insured of the first policy and subsequently completion of five continuous years would be applicable from the date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

F.1.13 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

F.1.14 Free look period

At the inception of the policy the Insured Person will be allowed a period of 30 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable. If Insured Person has not made any claim during the free look period, he will be entitled to the following, provided no claim has been settled or lodged for the period the policy has been in force:

a) A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured person and the stamp duty charges or;

b) where the risk has already commenced and the option of return of the policy is exercised, a deduction towards the proportionate risk premium for period on cover or;

c) Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

d) Free-look will not be applicable for policies with tenure less than one year.

e) Free-look not applicable in case of renewals.

All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

F.1.15 Redressal of grievance

ln case of any grievance the insured person may contact the company through

Website: https://www.royalsundaram.in

Grievance Redressal: https://www.royalsundaram.in/customer-service

You may call us at – 1860 258 0000, 1860 425 0000

Email:

1. Please raise a complaint with us through e mail – care@royalsundaram.in, and we would come back to you with a response in 24 hours.
2. In case you are not satisfied with our response or have not received any response in 24 hours, you may write to manager.care@royalsundaram.in
3. If you feel you are not heard of or have not received any response in 2 business days, you may escalate it to head.cs@royalsundaram.in
4. In case you are not happy with our response or have not received any response in 2 business days, you may approach gro@royalsundaram.in - GRO Contact Number – 9500413094

Sr. Citizen can email us at : seniorcitizengrievances@royalsundaram.in - Senior Citizen Grievance Number - 9500413019 (A separate e-mail id for Senior Citizens has been created for the ease and convenience of Senior citizens)

Fax us at: 044 – 7117 7140

Courier us your complaint at:

Royal Sundaram General Insurance Co. Limited

Vishranthi Melaram Towers,

No.2/319, Rajiv Gandhi Salai (OMR)

Karapakkam, Chennai – 600097

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the Redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Mr. T M Shyamsunder
Grievance Redressal Officer
Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers,
No.2/319, Rajiv Gandhi Salai (OMR)
Karapakkam, Chennai – 600097

For updated details of grievance officer, kindly refer the link http://www.royalsundaram.in

lf Insured person is not satisfied with the Redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for Redressal of grievance as per insurance Ombudsman Rules 2017.

Insurance Ombudsman addresses -https://www.cioins.co.in/ContactUs

Grievance may also be lodged at –

Registration of Complaints in Bima Bharosa by Policyholders:

1. Can directly register complaint in the **Bima Bharosa Portal** https://bimabharosa.irdai.gov.in/
2. Can send the complaint through Email to complaints@irdai.gov.in.
3. Can call Toll Free No. **155255** or **1800 4254 732**.

4. Apart from the above options, if it is felt necessary by the complainant to send the communication in physical form, the same may be sent to IRDAI addressed to:

   General Manager

   Insurance Regulatory and Development Authority of India(IRDAI)

   Policyholder's Protection & Grievance Redressal Department – Grievance Redressal Cell.

   Sy.No.115/1, Financial District, Nanakramguda,

   Gachibowli, Hyderabad – 500 032.

   No loading shall apply on renewals based on individual claims experience.

   Insurance is the subject matter of solicitation.

F.1.16 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

F.2 Specific Terms and Clauses

F.2.1 Alteration to the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement signed and stamped by Us. No one except Us can change or vary this Policy.

F.2.2 In case of non-disclosure of a condition, we can incorporate additional waiting period of not exceeding 36 months for the said undisclosed disease or condition from the date the un-disclosed condition was detected and continue with the policy subject to obtaining prior consent from you or Insured Person.

F.2.3 Where the non-disclosed condition allows us to continue the coverage by levying extra premium or loading based on the objective criteria laid down in the Board approved underwriting policy, we shall levy the same prospectively from the date of noticing the non-disclosed condition. However, in respect of policy contracts for a duration exceeding one year, If the un-disclosed condition is surfaced before the expiry of the policy term, we may charge the extra premium or loading retrospectively from the first year of issuance of the policy or renewal, whichever is later.

F.2.4 Reasonable Care

The Insured Person shall take all reasonable steps to safeguard against any Accident or Illnesses that may give rise to any claim under this Policy.

F.2.5 Material Change

It is a Condition Precedent to Our liability under the Policy that the Policyholder shall immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business at his own expense (refer Annexure I). We may, in its discretion, adjust the scope of cover and/or the premium paid or payable, accordingly. You

must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the contract.

F.2.6 Change of Policyholder

The policyholder may be changed only at the time of Renewal of the Policy. The new Policyholder must be a member of the Insured Person's immediate family. The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed upon request in case of his demise.

F.2.7 No Constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Policyholder/Insured Person which is in Our possession and not specifically informed by the Policyholder/Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

F.2.8 Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

F.2.9 Records to be maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period or until final adjustment (if any) and resolution of all Claims under this Policy.

F.2.10 Territorial Jurisdiction

The geographical scope of this Policy applies to events within India. All admitted or payable claims shall be settled in India in Indian rupees.

F.2.11 Policy Disputes

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

F.2.12 Renewal conditions

i. This Policy will automatically terminate at the end of the Policy Period. This Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium. All Renewal application should reach Us on or before the Policy Period End Date.

ii. We may in Our sole discretion, revise the Product and Renewal premium payable under the Policy provided that revision to the Renewal premium are in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

iii. The premium payable on renewal shall be paid to Us on or before the Policy Period End Date and in any event before the expiry of the **Grace Period**. For the purpose of this provision, Grace Period means a period of 30 days in case of one year immediately following the Policy Period End Date during which a payment can be made to renew this

Policy without loss of continuity benefits such as Waiting Periods and coverage of Pre Existing Diseases.

iv. Renewal of the Policy will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by You.

v. We reserve the right to carry out underwriting in relation to any alterations like increase/decrease in Sum Insured, change in plan/coverage, addition/deletion of members, addition/deletion of Medical Conditions, request at the time of Renewal of the Policy. Any request for acceptance of changes on renewal will be subject to underwriting. The terms and conditions of the existing Policy will not be altered.

vi. This product may be withdrawn by Us after due approval from the IRDAI. In case this product is withdrawn by Us, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDAI. We shall duly intimate You regarding the withdrawal of this product and the options available to You at the time of Renewal of this Policy.
In case of floater policies, children attaining 25 years at the time of renewal will be moved out of the floater into an individual cover however all continuity benefits on the policy will remain intact. Cumulative Bonus earned will be suitably passed on the fresh policy of child.

F.2.13 Communications & Notices

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

i. To Us, at the address as specified in Schedule of Insurance Certificate

ii. The Policyholder's, at the address as specified in Schedule of Insurance Certificate

iii. No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us

iv. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

F.2.14 Overriding Effect of Policy Schedule

In case of any inconsistency in terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

G Other Terms and Conditions

G.1 Claim Procedure

Provided that the due adherence/observance and fulfilment of the terms and conditions of this Policy (conditions and all Endorsements hereon are to be read as part of this Policy) shall so far as they relate to anything to be done or not to be done by the Insured and / or Insured person be a condition precedent to any liability of the Company under this Policy. Cashless and Reimbursement both Claims will be settled through TPA. The Claims Procedure is as follows:

G.1.1 For admission in Network Hospital (Cashless Claims)

Insured Person shall call the TPA helpline and furnish Membership Number, Policy Number and the Name of the Patient within 72 hours before admission to hospital for planned hospitalization and not later than 48 hours of admission in case of emergency hospitalization. The insured shall also provide to the TPA by e-mail or through TPA's web portal, the details of hospitalization like diagnosis, name of hospital, duration of stay in

hospital, estimated expenses of hospitalization etc. in the prescribed form available with the Insurance help desk at the Hospital. The Insured shall also provide any additional information or medical record as may be required by the medical panel of the TPA. After establishing the admissibility of the claim under the policy, the TPA shall provide a pre-authorisation to the hospital guaranteeing payment of the hospitalization expenses subject to the sum insured, terms conditions and limitations of the policy. The difference between the amount of pre-authorisation approved and the final hospital bill owing to deductions such as non-payable items, excluded items, policy sub-limits, copay amount, deductible amt etc, shall be borne by the insured.

G.1.2 For admission in Non-Network Hospital or into Network Hospital if cashless facility is not availed (Re-imbursement Claims)

- **Notice of claim:** Preliminary notice of claim with particulars relating to Policy number, Name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending hospital, should be given to the Insurer within 72 hours before admission in case of planned hospitalization, and not later than 48 hours or before discharge, in case of emergency hospitalization.
- **Submission of claim:** The insured shall submit the claim form along with attending physician's certificate duly filled and signed in all respects with the following claim documents not later than 30 days from the date of discharge.

Mandatory documents

1. Discharge summary (detailed) describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.
2. Original Settlement letter from the primary Insurer
3. Death summary in case of death of the insured person at the hospital.
4. First consultation papers
5. Doctor's prescriptions confirming diagnosis/advising hospitalization
6. All test reports such as X-rays, ECG, Scan, MRI, Pathology etc, including doctor's prescription advising such tests/investigations (CDs of angiogram, surgery etc need not be sent unless specifically sought).
7. Hospital Final Bill and advance and final hospital payment receipts, in Original.
8. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital.
9. F.I.R/MLC. in the case of Accidental injury and English translation of the same, if in vernacular language.
10. Detailed self-description stating the date, time, circumstances and nature of injury/Accident in case of claims arising out of injury (in the absence of FIR)
11. Legal heir certificate in the absence of nomination under the policy, in case of death of the proposer. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required.
12. For b) Cataract claims - IOL sticker c) PTCA claims - Stent sticker. d) Implant sticker for surgeries involving implants

13. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that Original claim documents are retained at their end.
14. Complete medical records of past hospitalization/treatment, if any.
15. For domiciliary hospitalization claims, a certificate from the attending doctor confirming that the condition of the patient is such that he/she is not in a condition to be removed to a hospital Or there is non availability of bed in the hospital near insured's place of stay.
16. Cancelled cheque leaf in the name of the proposer clearing showing the IFSC code and account holder's name
17. CKYC number of the proposer. If the insured is not having an existing CKYC number – duly filled CKYC format of the Proposer along with photograph ID and address proof as per AML guidelines of Govt of India.

Whenever a primary claim is lodged with other insurer and claim above deductible is lodged with Us, a copy of original documents (submitted with the primary insurer) may be submitted to Us

Documents to be submitted if specifically sought:

1. Copy of indoor case records (including nurse's notes, OT notes and anesthetists' notes, vitals chart). (if available)
2. Copy of extract of Inpatient Register.
3. Attendance records of employer/educational institution.
4. Attending Physician's certificate clarifying
    - reason for hospitalization and duration of hospitalization
    - history of any self-inflicted injury
    - history of alcoholism, smoking
    - history of associated medical conditions, if any
6. Previous master health check-up records/pre-employment medical records, if any.
7. Any other document necessary in support of the claim on case to case basis.

The claim documents should be sent to the address stated in the policy schedule.

G.2 Claim Assessment

We will assess all admissible claims under the Policy in the following progressive order –

1. As per Policy terms and conditions and exclusions, sub-limits under the policy.
2. The deductible opted under the policy against the sum insured, shall be deducted from the amount arrived at as above.
3. The amount assessed under G 2 (2) shall be subject to availability of sum insured opted the policy.

Annexure-A

List I – Items for which coverage is not available in the policy

SI No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES

30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY

60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II — Items that are to be subsumed into Room Charges

SI No	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC

22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III — Items that are to be subsumed into Procedure Charges

SI No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE

16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatment

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALIZATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure B – Product Benefit Table

	Product Type	Deductible on Annual Aggregate Basis
Sr No	**Product Feature**	**Scope of Benefits**
1	Sum Insured	10 Lakhs, 15 Lakhs 20 Lakhs, 25 lakhs, 30 lakhs, 35 Lakhs, 40 Lakhs, 45 Lakhs, 50 lakhs, 55 lakhs, 60 lakhs, 65 Lakhs, 70 Lakhs, 75 lakhs, 80 lakhs, 85 lakhs 90 lakhs, 95 Lakhs
2	Deductible	For 10- 95 lakhs Sum Insured - 5 lakhs deductible, For 15 - 90 lakhs Sum Insured - 10 lakhs deductible, For 10 - 85 lakhs Sum Insured - 15 lakhs deductible, For 30 - 80 lakhs Sum Insured - 20 lakhs deductible, For 25-75 lakhs Sum Insured - 25 Lakhs deductible
3	Inpatient Care	Covered up to Sum Insured
4	Modern treatments	Covered Up to Sum Insured
5	Pre and post hospitalization expenses	60/90 days, Covered up to Sum Insured.
6	Day care procedures	Covered up to Sum Insured (All Day Care Treatments), Pre and Post-hospitalization Medical Expenses are payable up to 30 days under Day Care Procedures.
7	Organ Donor Expenses	Covered up to Sum Insured
8	Domiciliary Hospitalization	Covered up to Sum Insured, Pre and Post-hospitalization Medical Expenses are payable up to 30 days under Domiciliary Hospitalization
9	AYUSH Treatment	Covered up to Sum Insured
10	Ambulance Cover including App-based Cab cover#	Covered up to Rs.3000 per hospitalization.
11	Second Opinion for 22 specified Critical Illness	Available once during policy year for 22 specified critical illnesses
12	Home Care treatment	Up to Rs. 50000 per event per Insured Person and Rs. 1 Lakh per policy year per Insured Person
13	Life Protect Benefit$	10% of Sum Insured per policy year
	Waiting Periods	
14	Initial Waiting Period	30 days
15	Pre-Existing Diseases waiting period	36 months
16	Specific waiting period*	24 months
	Optional Benefit	
17	Reduction in Pre-Existing	Reduction in PED waiting period from 36 months to 24 months.

	Diseases waiting period	
	Notes:	
	*24 months waiting period for the following illnesses- a) Cataract b) Stones in biliary and urinary systems c) Hernia / Hydrocele d) Hysterectomy for any benign disorder e) Lumps / cysts / nodules / polyps / internal tumours f) Gastric and Duodenal Ulcers g) Surgery on tonsils / adenoids h) Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse i) Fissure / Fistula / Haemorrhoid j) Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media k) Benign Prostatic Hypertrophy l) Knee/Hip Joint replacement m) Dilatation and Curettage n) Varicose veins o) Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis p) Chronic Renal Failure or end stage Renal Failure or Chronic liver failure	
	#To and fro hospital Cab Fare on producing the app-based Cab Bill up to the limit specified. Not applicable for day care procedures	
	$This can be used in case of Life Threatening Conditions only and once in a policy year. This is an additional benefit over & above Sum Insured	
	Policy Tenure	1/2/3 Years
	Cover Type	Individual/ Family Floater covering 2 Adults & up to 4 Children (Proposer need not to be covered in the same policy)
	Entry age	Adult: 18 years to 65 years Dependent Children: 91 days to 25 yrs (After 25 years, Dependent children will be covered as adults in a separate policy)
	Room Rent	No Room Rent capping
	Discount on Multiyear policy	6% discount for 2 years policy 9% discount for 3 years policy

Annexure C

Format to be filled up by the proposer for change in occupation of the Insured

Policy No	Name of the Insured	Date of birth/Age	Relationship with Proposer	City of residence	Previous Occupation or Nature of Work	New Occupation or Nature of Work

Place: _____ **Proposer's**
Signature_____

Date: _____
Name:_____

(DD/MM/YYYY)

Council for Insurance Ombudsmen

Contact details:
Address:
Council for Insurance Ombudsmen,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

INSURANCE OMBUDSMAN OFFICE LIST

The contact details of **Insurance Ombudsman Office** details are as below:

https://www.cioins.co.in/ContactUs

WHAT IF I EVER NEED TO COMPLAIN?

We hope, of course, that you will never feel the need to complain. Nevertheless, sometimes things do go wrong. When they do, we want to know straight away, so we can put them right as quickly as possible, and take steps to make sure they don't happen again.

In all instances, call our Customer Services at our Chennai office at 1860 258 0000 or e-mail at care@royalsundaram.in or write us to Royal Sundaram General Insurance Co. Limited, Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

Royal Sundaram General Insurance Co. Limited

IRDAI Registration No.102. | CIN: U67200TN2000PLC045611