Policy Document – Part II

1. Terms & Conditions

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, conditions and exclusions of the Policy subject to availability of Sum Insured and Cumulative Bonus (if any).

2. Interpretations & Definitions

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

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

Def. 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.

Def. 3. **Base Sum Insured** means the amount specified as Sum Insured at the inception of a Policy Year and in the event the Policy is upgraded or downgraded on any continuous Renewal, then exclusive of Cumulative Bonus, if any, the Sum Insured for which premium is paid at the commencement of the Policy Year for which the prevalent upgrade or downgrade is sought.

Def. 4. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization approved.

Def. 5. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 6. **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 : Which is not in the visible and accessible parts of the body
b) External Congenital Anomaly: Which is in the visible and accessible parts of the body

Def. 7. **Contribution** is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion of sum insured.

This clause shall not apply to any Benefit offered on fixed benefit basis.

Def. 8. **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

Def. 9. **Critical Illness** means the following:

1. Cancer of Specified Severity

A malignant tumour characterised 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 and confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

- Tumours showing the malignant changes of carcinoma in situ and tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter.
- Chronic lymphocyctic leukaemia less than RAI stage 3.
- Microcarcinoma of the bladder.
- All tumours in the presence of HIV infection.

2. First Heart Attack-of Specified Severity

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this shall be evidenced by all of the following criteria:

a) A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain);
b) new characteristic electrocardiogram changes;
c) elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

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

3. Open Chest CABG

The actual undergoing of open chest Surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of Surgery has to be confirmed by a specialist medical practitioner.

The following are excluded:

a) Angioplasty and/or any other intra-arterial procedures;
b) Any key-hole or laser Surgery.

4. Open Heart Replacement or Repair of Heart Valves

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.

5. Coma of Specified Severity

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:

a) no response to external stimuli continuously for at least 96 hours;
b) life support measures are necessary to sustain life; and
c) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

6. Kidney Failure Requiring Regular Dialysis

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

7. Stroke Resulting in Permanent Symptoms

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 atleast 3 months has to be produced.

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

8. Major Organ/Bone Marrow Transplant

The actual undergoing of a transplant of:

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

The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

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

9. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist medical practitioner 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.

10. Motor Neurone Disease with Permanent Symptoms

Motor neurone 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.

11. **Multiple Sclerosis with Persisting Symptoms**

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

- investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis; and
- there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months; and
- well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

Other causes of neurological damage such as SLE and HIV are excluded.

Def. 10. **Cumulative Bonus (No Claim Bonus)** shall mean any increase in the Base Sum Insured granted by Us without an associated increase in premium.

Def. 11. **Day Care Center:** A day care centre means any institution established for Day Care Treatment of illness and/or injuries or a medical set-up within a Hospital and which has been registered within the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:-

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

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

a) undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement and;
b) which would have otherwise required a hospitalization of more than 24 hours.

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

Def. 13. **Deductible:** Deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Def. 14. **Diagnostic Tests:** Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

Def. 15. **Disclosure to Information Norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 16. **Domiciliary Hospitalisation**: 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:

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

Def. 17. **Emergency** means a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

Def. 18. **Emergency Care** means management for a severe Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

Def. 19. **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 continues 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.

Def. 20. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.

Def. 21. **Hospital** means any institution established for Inpatient care and Day Care Treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

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

Only for the purposes of any claim or treatment permitted to be made or taken outside India in accordance with Section 3.16 and Section 3.17, **Hospital (outside India)** means an institution (including nursing homes) established outside India for indoor medical care and treatment of sickness and injuries which has been registered and licensed as such with the appropriate local or other authorities in the relevant area, wherever applicable, and is under the constant supervision of a Medical Practitioner. The term Hospital shall not include a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, old age home.

Def. 22. **Hospitalization** or **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.

Def. 23. **Injury:** Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def. 24. **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.

Def. 25. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life

support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def. 26. **Illness** means sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

i. Acute condition- Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
ii. Chronic condition- A chronic condition is defined as a disease, illnesss, or injury that has one or more of the following characteristics:- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests- it needs ongoing or long-term control or relief of symptoms –it requires your rehabilitation or for you to be specifically trained to cope with it- it continues indefinitely – it comes back or is likely to come back.

Def. 27. **Inpatient** means the Insured Person's admission to for treatment in a Hospital for more than 24 hours for a covered event.

Def. 28. **Inpatient Care** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

Def. 29. **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.

Def. 30. **Maternity Expenses** shall include—

a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization)
b) expenses towards lawful medical termination of pregnancy during the Policy Period

Def. 31. **Medical Advise:** Any **c**onsultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

Def. 32. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Def. 33. **Medical Practitioner:** A Medical Practitioner is 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 setup by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence.

Def. 34. **Medically Necessary:** Medically necessary treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a) is required for the medical management of the Illness or injury suffered by the insured;
b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c) must have been prescribed by a Medical Practitioner;
d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

Def. 36. **New Born Baby** means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

Def. 37. **Notification of Claim** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

Def. 38. **Non-Network** means any Hospital, Day Care Centre or other provider that is not part of the Network.

Def. 39. **OPD Treatment** is one in which the Insured Person visits a clinic/ hospital, or associated facility like a consultation room, for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or In-Patient.

Def. 40. **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).

Def. 41. **Policy Period** means the period between the date of commencement and the expiry date specified shown in the Schedule of Insurance Certificate.

Def. 42. **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.

Def. 43. **Pre-existing Disease** means any condition, ailment or injury or related condition(s) for which the Insured Person had signs or symptoms, and / or were diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first Policy issued by Us.

Def. 44. **Pre-hospitalization Medical Expenses**

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

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

Def. 45. **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 Hospitalisation was required and;
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Def. 46. **Portability** means transfer by an individual health insurance policy holder (including family cover) of the credit gained for Pre-existing Disease and time bound exclusions if he/she chooses to switch from one insurer to another.

Def. 47. **Product Benefits Table** means the Product Benefits Table issued by Us and accompanying this Policy and annexures thereto.

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

Def. 49. **Rehabilitation**: Treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.

Def. 50. **Reasonable and Customary Charges** means 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.

Def. 51. **Re-load Sum Insured** means the restoration of hundred percent of the Base Sum Insured in accordance with Section 3.9 (Re-load of Sum Insured) of the Policy.

Def. 52. **Renewal** defines 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 all waiting periods.

Def. 53. **Room rent** means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

Def. 54. **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.

Def. 55. **Subrogation** shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

Def. 56. **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 Period.

Def. 57. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

Def. 58. **Unproven/Experimental treatment:** Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

Def. 59. **We/Our/Us** means Royal Sundaram General Insurance Company Limited.

Def. 60. **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.

3. Benefits

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 subsidiary limit specified in the Product Benefits Table, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted for in the Product Benefits Table and as shown in the Schedule of Insurance Certificate :

3.1. Inpatient Care

We will cover Medical Expenses for:

(a) Medical Practitioners' fees;

(b) Room Rent, boarding expenses;

(c) Intensive Care Unit charges;

(d) Diagnostics Procedures charges;

(e) Medicines, drugs and consumables;

(f) Nursing Charges;

(g) Intravenous fluids, blood transfusion, injection administration charges;

(h) Anesthesia, Blood, Oxygen, Operation theatre charges, surgical appliances;

(i) The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.

3.2. Pre-hospitalization Medical Expenses

We will, on a reimbursement basis cover expenses for consultations, investigations and medicines of an Insured Person which are incurred due to an Accident, Injury or Illness immediately prior to the Insured Person's date of Hospitalization up to the limits specified in the Product Benefits Table, provided that a claim has been admitted under Inpatient Care under Section 3.1 above and is related to same illness/condition.

3.3. Post-hospitalization Medical Expenses

We will, on a reimbursement basis cover expenses for consultations, investigations and medicines of an Insured Person which are incurred due to an Accident, Injury or Illness immediately post discharge of the Insured Person's from the Hospital up to the limits specified in the Schedule, provided that a claim has been admitted under Inpatient Care under Section 3.1 above and is related to same illness/condition.

3.4. Day Care Treatment

We will cover Medical Expenses of an Insured Person in case of 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 Center on the recommendation of a Medical Practitioner. Any OPD Treatment undertaken in a Hospital/Day Care Center will not be covered.

3.5. Emergency ambulance

We will cover Reasonable and Customary Charges for ambulance expenses up to the limit specified in Product Benefit Table that are incurred towards transportation of an Insured Person by surface transport following an Emergency to the nearest Hospital with adequate facilities. These charges are payable if:

(a) The ambulance service is offered by a healthcare or ambulance service provider; and

(b) We have accepted an Inpatient Care claim under the provisions of Section 3.1 above.

3.6. 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 Advise;

(c) We have admitted a claim under Section 3.1 towards Inpatient Care.

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.

3.7. Domiciliary Hospitalization

We will cover Medical Expenses 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 payment for Post Hospitalization Medical Expenses shall not be payable.

3.8. No Claim Bonus

We will increase Your Sum Insured as per the variant opted, at the end of the Policy Year if the Policy is renewed with Us provided that there are no claims paid/outstanding in the expiring Policy Year by any Insured Person:

- In any Policy Year, the accrued No Claim Bonus shall not exceed 50% of Base Sum Insured (in case of Classic Variant) and 100% of Base Sum Insured (in case of Supreme & Elite variant) available in the renewed Policy;
- You understand and agree that the sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the increase in total Sum Insured;
- Any earned No Claim Bonus will not be reduced for claims made in the future;
- If two or more Individual Policies of Lifeline are renewed as Family Floater Policy, then the No Claim Bonus of each member under Individual policies to be carried forward for credit in the Floater policy shall be least No Claim Bonus available amongst the Insured Persons in their expired Individual Policies.

- No Claim Bonus which is accrued during the claim free year will be available to those Insured Persons who were insured in such claim free year and continued to be insured in the subsequent Policy Year;
- If the Base Sum Insured is increased/decreased, No Claim Bonus will be calculated on the basis of Base Sum Insured of the last completed Policy Year and will be capped to max No Claim Bonus allowed for renewed variant Base Sum Insured;
- No Claim Bonus shall be applicable on an annual basis subject to the continuation of the Policy;
- The entire No Claim Bonus will be forfeited if the Policy is not continued/renewed on or before Policy Period End Date or the expiry of the Grace Period whichever is later.

3.9. Re-load of Sum Insured

We will provide a 100% Re-load of Sum Insured once in a Policy Year, provided that:

a) the Base Sum Insured and No Claim Bonus (if any) is insufficient as a result of previous claims in that Policy Year;

b) The Re-load Sum Insured shall not be available for claims towards an Illness/Disease/Injury (including complications) for which a claim has been paid or accepted as payable in the current Policy Year for the same Insured Person under Inpatient Care under Section 3.1;

c) The Re-load of Sum Insured will be available only for claims made by Insured Persons in respect of future claims that become payable under Section 3 of the policy and shall not apply to the first claim in the Policy Year;

d) The Reload of Sum Insured shall not be available for claims towards an Illness/Disease/Injury (including complications) under Worldwide Emergency Hospitalization under Section 3.16 and International Treatment abroad for 11 specified Critical Illness under Section 3.17;

e) The Re-load Sum Insured will not be considered while calculating the No Claim Bonus;

f) In the policy is issued on a floater basis, the Re-load Sum Insured will also be available on the floater basis;

g) If the Re-load Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

For any single claim during a Policy Year the maximum Claim amount payable shall be sum of:

i. The Sum Insured
ii. No Claim Bonus

During a Policy Year, the aggregate claim amount payable, subject to admissibility of the claim, shall not exceed the sum of:

i. The Sum Insured
ii. No Claim Bonus
iii. Re-load Sum Insured

3.10. Ayush Treatment

We will reimburse the Medical Expenses incurred for Inpatient Care taken under Alternative Treatment in a government Hospital or in any institute recognized by the government and/or accredited by the Quality Council of India/National Accreditation Board on Health. Our maximum liability will be limited up to the amount provided in the Product Benefits Table.

Exclusion 4 (e)(iv) does not apply to this benefit

3.11. Vaccination for Animal Bite

We will cover Medical Expenses of OPD Treatment for vaccinations including inoculation and immunizations in case of post-bite treatment. Our maximum liability will be limited up to the amount provided in the Product Benefits Table. This benefit is available only on reimbursement basis.

3.12. Health Checkup

We will arrange for a health checkup as per Your plan eligibility as defined in the Product Benefits Table provided that You or any Insured Person has requested for the same. We will cover health check-ups arranged by Us through Our empanelled Network Provider, provided that:

i. 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;

ii. For Classic Variant – Available once every 3rd Policy Year; For Supreme & Elite Variant – Available at each renewal.

3.13. Preventive Healthcare & Wellness

We will provide various Preventive Healthcare & Wellness related services that will help You to assess Your health status and aid in improving Your overall well being. Various Preventive Healthcare & Wellness services include Health related articles on Our website, access to various preferred health maintenance network etc.

3.14 Second Opinion for Critical Illness (For Supreme & Elite Variant only)

We will provide You a second opinion from Network Provider or 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 option 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

3.15 Emergency Domestic Evacuation (For Supreme & Elite Variant only)

We will reimburse You for Your reasonable & necessary transportation from one Hospital to another Hospital in case of life threatening emergency condition for treatment of an Illness or Injury which is admissible and payable under the Policy, subject to:

i. Certification by the treating Medical Practitioner of such life threatening emergency condition and confirming that current Hospital does not have suitable medical equipment & technology for the life threatening condition;

ii. Our maximum liability will be limited to the limits specified in Product Benefits Table;

iii. You understand and agree that any expenses over and above the limits specified, You will have to make the payment directly to the service provider;

iv. It is hereby agreed and understood that service provided by the Service Provider under this benefit, We make no representation and/or give no guarantee and/or assume no responsibility for the appropriateness, quality or effectiveness of the service sought or provided. The Emergency Domestic Evacuation service shall be on best efforts basis;

v. This benefit can be availed once by an Insured Person during a Policy Year.

3.16 Worldwide Emergency Hospitalization (For Elite Variant only)

We will cover Medical Expenses of the Insured Person incurred outside India, up to limits specified in the Product Benefits Table, provided that:

a) The treatment is Medically Necessary and has been certified as an Emergency by a Medical Practitioner, where such cannot be postponed until the Insured Person has returned to the India and is payable under Section 3.1 of the Policy;

b) The Medical Expenses payable shall be limited to Inpatient Hospitalization only;

c) Any payment under this Benefit will only in Indian rupees on a cashless or re-imbursement basis;

d) The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion;

e) Each admissible claim will be subject to a deductible of USD 1,000;

f) Our overall liability will be limited to 50% of Sum Insured upto a max of Rs.20 lacs;

g) Re-load of Sum Insured will not be available for this benefit;

h) This benefit is available as cashless facility through pre-authorization by Our Service Provider as well as re-imbursement basis;

   a. In the event of an Emergency, the Insured Person or Network Hospital shall call Our Service Provider immediately, on the helpline number specified in the Insured Person's health card, requesting for a pre-authorization for the medical treatment required;

   b. Our Service Provider will evaluate the request and the eligibility of the Insured Person under the Policy and call for more information or details, if required;

   c. Our Service Provider will communicate directly to the Hospital whether the request for pre-authorization has been approved or denied;

   d. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider shall be borne by the Insured Person;

   e. It is agreed and understood that We shall not cover any costs or expenses incurred in relation any persons accompanying the Insured Person during the period of Hospitalization, even if such persons are also Insured Persons.

i) It is hereby agreed and understood that in the pre-authorization made by the Service Provider under this Policy or in making any payment under this Policy or providing information on the nearest Hospital, We make no representation and/or give no guarantee and/or assume no responsibility for the appropriateness, quality or effectiveness of the treatment/facilities sought or provided. The Worldwide Emergency Hospitalization service shall be on best efforts basis.

j) Exclusion 4 (e)(xxxiv) does not apply to this benefit.

3.17 International Treatment for 11 specified Critical Illness (For Elite Variant only)

We will cover Reasonable & Customary Medical Expenses of the Insured Person incurred outside India for treatment of 11 specified Critical Illness if the Insured Person suffers from any of these 11 Critical Illness during the Policy Period and while the Policy is in force, provided that:

(a) The symptoms of the Critical Illness first occur or manifest itself during the Policy Period and after completion of the 90 days initial waiting period;

(b) The Critical Illness is diagnosed by a Medical Practitioner within India during the Policy Period and after completion of the 90 day initial waiting period;

(c) Medical treatment for the Specified Illness is taken outside India;

(d) Our maximum liability in first Policy Year will be limited to 50% of Sum Insured;

(e) All claims will be subject to 20% co-payment;

(f) Re-load of Sum Insured will not be available for this benefit;

(g) We will cover the one time Return Airfare of Insured Person for whom claim has been accepted, upto a maximum of Rs.300,000 on reimbursement basis only.

(h) The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. You further understand and agree that where on the date of discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion;

(i) This benefit is available only as cashless facility through pre-authorization by Our Service Provider;

(j) For this benefit, Critical Illness means the following:

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

(k) Exclusion 4 (e)(xxxiv) does not apply to this benefit.

4. Exclusions

We shall not be liable under this Policy for any claim in connection with or in respect of the following:

a. 30 days Initial Waiting Period

We will not cover any treatment taken during the first 30 days since the date of commencement of the Policy, unless the treatment needed is the result of an Accident/Injury. This exclusion shall not

apply for any subsequent and continuous Renewals of Your Policy provided that there is no break in the insurance cover.

b. Pre-Existing Diseases

Claim will not be admissible for any Medical Expenses incurred as Hospitalization Expenses for diagnosis/treatment of any Pre-existing Diseases;

(i) for Classic variant, until 48 months of continuous coverage have elapsed since the inception of the first Policy with Us;

(ii) for Supreme variant, until 36 months of continuous coverage have elapsed since the inception of the first Policy with Us;

(iii) for Elite variant, until 24 months of continuous coverage have elapsed since the inception of the first Policy with Us.

Where the Policy is renewed for enhanced Sum Insured, waiting periods would start and apply afresh for the amount of increase in Sum Insured

c. Specific Waiting Period

A waiting period of 24 months shall apply and will be covered from the commencement of the 3rd Policy Year as long as the Insured Person has been insured continuously under the Policy without any break, to the treatment of the following, whether medical or surgical for all Medical Expenses along with their complications on treatment towards;

1. Cataract
2. Stones in biliary and urinary systems
3. Hernia / Hydrocele
4. Hysterectomy for any benign disorder
5. Lumps / cysts / nodules / polyps / internal tumours
6. Gastric and Duodenal Ulcers
7. Surgery on tonsils / adenoids
8. Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
9. Fissure / Fistula / Haemorrhoid
10. Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
11. Benign Prostatic Hypertrophy
12. Knee/Hip Joint replacement
13. Dilatation and Curettage
14. Varicose veins
15. Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
16. Diabetes and related complications
17. Chronic Renal Failure or end stage Renal Failure

If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing the pre-existing waiting periods shall apply.

d. Personal Waiting Periods

A special waiting period not exceeding 48 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.

e. Permanent Exclusions

We will not be liable under any circumstances, for any claim in connection with or with regard to any of the following permanent exclusions and any such other exclusions as may be specified in the Schedule of Insurance Certificate :-

i. Addictive conditions and disorders

Treatment related to addictive conditions and disorders, or from any kind of substance abuse or misuse including alcohol abuse or misuse.

ii. Adventure or Hazardous Sports

Active participation in adventure or hazardous sports including but not limited to para-jumping, rock climbing, mountaineering, motor racing, horse racing or deep-sea diving.

iii. Ageing and puberty

Treatment to relieve symptoms caused by ageing, puberty, or other natural physiological cause, such as menopause and hearing loss caused by maturing or ageing.

iv. Alternative treatment

Any Alternative Treatment except for the benefits under Section 3.10 (Ayush Treatment)

v. 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, RMO charges, night charges, registration, documentation and filing, surcharges. Service charges levied by the Hospital under whatever head.

vi. Artificial life maintenance

Artificial life maintenance, including life support machine used to sustain a person, who has been declared brain dead, as demonstrated by:

1. Deep coma and unresponsiveness to all forms of stimulation;
2. Absent pupillary light reaction;
3. Absent oculovestibular and corneal reflexes; or
4. Complete apnea

vii. 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.

viii. Circumcision

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

ix. 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

x. Congenital conditions

Treatment for any Congenital Anomaly.

xi. 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.

xii. Cosmetic surgery

Treatment undergone purely for cosmetic or psychological reasons to improve appearance. However, this exclusion does not apply where medically required as a part of treatment for cancer, accidents and burns to restore functionality.

xiii. 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.

xiv. 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 3.3 above.

xv. Eyesight

Treatment to correct refractive errors of the eye, unless required as the result of an Accident. We will not pay for routine eye examinations, contact lenses, spectacles or laser eye sight correction.

xvi. Health hydros, nature cure, wellness clinics etc.

Treatment or services received in health hydros, nature cure clinics or any establishment that is not a Hospital.

xvii. HIV and AIDS

Any treatment for, or treatment arising from, Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS), including any condition that is related to HIV or AIDS.

xviii. Hereditary conditions (Specified)

Any treatment arising from and/or taken for Crohn's Disease ,Ulcerative colitis, Cystic kidneys, Neurofibromatosis, Factor V Leiden Thrombophilia, Familial Hypercholesterolemia, Hemophilia, Hereditary Fructose Intolerance, Hereditary Hemochromatosis, Hereditary Spherocytosis.

xix. Hospitalization for observation or investigative purpose only

Hospitalization undertaken for observation or for investigations only and where no medical treatment is provided.

xx. 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. External and or durable medical/non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc.

g. 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.

h. Nurses hired in addition to the Hospital's own staff.

xxi. Psychiatric and Psychosomatic Conditions

Treatment of any mental illness or sickness or disease including a psychiatric condition, disorganisation of personality or mind, or emotions or behaviour, Parkinson's or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness or general debility or exhaustion ("run-down condition");

xxii. Obesity

Treatment for obesity.

xxiii. OPD Treatment

OPD Treatment is not covered except for Section 3.11 (Vaccination for Animal Bite) that are taken on OPD Treatment basis upto the limit provided in the Product Benefits Table.

xxiv. Preventive Care

All preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment as covered under Section 3.11 (Vaccination for Animal Bite),

xxv. Reproductive medicine

a. Any type of contraception, sterilization, termination of pregnancy or Family planning.

b. Treatment to assist reproduction, including IVF treatment.

c. Any expense incurred on treatment arising from or traceable to pregnancy (including voluntary termination of pregnancy, childbirth, miscarriage, abortion or complications of any of these, including caesarean section.

However, the above exclusions do not apply to treatment for ectopic pregnancy.

xxvi. Self-inflicted injuries

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

xxvii. Sexual problems and gender issues

Treatment of any sexual problem including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction.

xxviii. Sexually transmitted diseases

Treatment for any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.

xxix. Sleep disorders

Treatment for sleep apnea, snoring, or any other sleep-related breathing problem.

xxx. Speech disorders

Treatment for speech disorders, including stammering unless the disorder occurs directly due to an Accident.

xxxi. Stem cell implantation

Stem cell implantation, harvesting, storage, or any kind of treatment using stem cells.

xxxii. 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.

xxxiii. Treatment for developmental problems

Treatment for, or related to developmental problems, including but not limited to:

a. learning difficulties, such as dyslexia;
b. behavioral problems, including attention deficit hyperactivity disorder (ADHD);
c. deviated nasal septum (straitening of the nasal tract).

xxxiv. Treatment received outside India

Any treatment received outside India. This exclusion does not apply for Section 3.16 (Worldwide Emergency Hospitalization) and Section 3.17 (International Treatment for Critical Illness).

xxxv. Unproven/Experimental treatment

Unproven/Experimental Treatment, including medication, which in competent Medical Practitioner's opinion is experimental or has not generally been proved to be effective.

xxxvi. Unrecognised physician or Hospital:

a. Treatment provided by a Medical Practitioner who is not recognized by the Medical Council of India.

b. Treatment in any hospital or by any Medical Practitioner or any other provider of services that We have blacklisted as listed on Our website.

c. Treatment provided by anyone with the same residence as Insured Person or who is a member of the Insured Person's immediate family.

xxxvii. Unrelated diagnostic, X-ray or laboratory examinations

Charges incurred at a Hospital primarily for evaluative or diagnostic or observation purposes for which no active treatment is given, X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalization.

xxxviii. Unlawful Activity

Any condition as a result of Insured Person committing or attempting to commit a breach of law with criminal intent.

xxxix. Any costs or expenses specified in the List of Expenses Generally Excluded at Annexure II.

5. Claim Procedure

Provided that the due adherence/observance and fulfillment 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. The Claims Procedure is as follows:

a) **For admission in Network Hospital**

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 fax or e-mail, 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.

b) For admission in Non-Network Hospital or into Network Hospital if cashless facility is not availed

- **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 incase 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. Test reports and prescriptions relating to First / Previous consultations for the same or related illness.

2. Case history / Admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.

3. Death summary in case of death of the insured person at the hospital.

4. Hospital Receipts / bills / cash memos in Original (including advance and final hospital settlement receipts).

5. All test reports for 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).

6. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital.

7. F.I.R/MLC. in the case of accidental injury and English translation of the same, if in any other language.

8. Detailed self-description stating the date, time, circumstances and nature of injury/accident in case of claims arising out of injury.

9. 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 by Us.

10. For a) maternity claims, Discharge Summary mentioning LMP, EDD & Gravida b)Cataract claims - IOL sticker c) PTCA claims - Stent sticker.

11. Copies of health insurance policies held with any other insurer covering the insured persons.

12. 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.

13. 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.

14. Additional documents for Emergency Domestic Evacuation:

    a. Certification by the treating Medical Practitioner of such life threatening emergency condition and confirming that current Hospital does not have suitable medical equipment & technology for the life threatening condition.

    b. Bills/Receipts of transportation agency/ambulance company/air ambulance receipts.

15. Additional documents for Worldwide Emergency Hospitalization and International Treatment for 11 specified Critical Illness– Insured Person passport, Visa, Tickets and Boarding Passes.

Documents to be submitted if specifically sought:

1. Copy of indoor case records (including nurse's notes, OT notes and anesthetists' notes, vitals chart).

2. Copy of extract of Inpatient Register.

3. Attendance records of employer/educational institution.

4. Complete medical records (including indoor case records and OP records) of past hospitalization/treatment, if any.

5. 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:

Health Claims Department

Royal Sundaram General Insurance Co Ltd

Vishranthi Melaram Towers,

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

Karapakkam, Chennai - 600097

Payment of Claim

- No liability under the Policy will be admitted, if the claim is fraudulent or supported by fraudulent means.
- Insured must give at his expense, all the information asked by Us about the claim and he must help to take legal action against anyone if required.
- If required the Insured / Insured Person must give consent to obtain Medical Report from Medical Practitioner at Our expense.
- If required the Insured or Insured Person must agree to be examined by a medical practitioner of Our choice at Our expense.
- All claims under this Policy shall be payable in Indian Currency. All medical treatments for the purpose of this insurance will have to be taken in India only except for Worldwide Emergency Hospitalization and International Treatment for 11 specified Critical Illness.
- Benefits payable under this policy will be paid within 30 days of the receipt of last necessary document.
- All claims are to be notified to Us within a timeline as per Section 5(b). In case where the delay in intimation is proved to be genuine and for reasons beyond the control of the Insured Person or Nominee specified in the Schedule of Insurance Certificate, We may condone such delay and process the claim, We reserve a right to decline such requests for claim process where there is no merit for a delayed claim. Please note that the waiver of the time limit for notice of claim and submission of claim is at Our evaluation.
- We shall be liable to pay interest at 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed, for sums paid or payable under this Policy, upon acceptance of an offer of settlement by the insured but there is a delay in payment beyond 7 days the date of acceptance.
- At the time of claim settlement, We may insist on KYC documents of the Proposer as per the relevant AML guidelines in force.

6. Standard Terms and Conditions

a. Disclosure to Information Norm

The policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration, claim form declaration, medical history on the claim form and connected documents, or any material information having been withheld by You or

any one acting on Your behalf, under this Policy. You further understand and agree that We may at Our sole discretion cancel the Policy and the premium paid shall be forfeited to Us.

b. Observance of terms and conditions

The due adherence/observance and fulfillment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured Person, shall be a Condition Precedent to any liability to make payment under this Policy .

c. 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.

d. Material Change

It is a Condition Precedent to the Our's 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 III). 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.

e. Subrogation

The Insured Person shall do and concur in doing and permit to be done all such acts and things as may be necessary or required by Us, before or after indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which We are or would become entitled or subrogated. Neither You nor any Insured Person shall do any acts or things that prejudice these subrogation rights in any manner. Any recovery made by Us pursuant to this clause shall first be applied to the amounts paid or payable by Us under this Policy and the costs and expenses incurred by Us in effecting the recovery, whereafter We shall pay the balance amount to You. This clause shall not apply to any Benefit offered on a fixed benefit basis (like Hospital Cash benefit).

f. Contribution

If two or more policies are taken by You during the same period from one or more Insurers to indemnify treatment costs and the amount of claim is within the Sum Insured limit of any of the policies, You will have the right to opt for a full settlement of Your claim in terms of any of Your policies.

Where the amount to be claimed exceeds the Sum Insured under a single policy after considering Deductible, Co-payments (if applicable), You can choose the insurer with which You would like to settle the claim. Wherever We receive such claims We have the right to apply the Contribution clause while settling the claim.

g. 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.

h. 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. Such change would be solely subject to Our discretion and payment of premium by You. The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed upon request in case of his demise or in case of divorce during the Policy Period.

i. 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.

j. Free Look Provision

You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You may cancel the Policy stating the reasons for cancellation and provided that no claims have been made under the Policy, We will refund the premium paid by You after deducting the amounts spent on any medical checkup, stamp duty charges and proportionate risk premium for the period on cover. All rights and benefits under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. The free look provision is not applicable and available at the time of Renewal of the Policy.

k. Cancellation/ Termination (other than Free Look cancellation)

1. Cancellation by Insured Person:

You may terminate this Policy during the Policy Period by giving Us at least 30 days prior written notice. We shall cancel the Policy and refund the premium for the balance of the Policy Period in accordance with the table below provided that no claim has been made under the Policy by or on behalf of any Insured Person.

Cancellation date upto (x months) from the Policy Period Start Date	Refund of Premium (basis Policy Period)		
	1 Year	2 Year	3 Year
Upto 1 month	75%	87%	91%
Upto 3 months	50%	74%	82%
Upto 6 months	25%	61.5%	73.5%
Upto 12 months	0%	48.5%	64.5%
Upto 15 months	NA	24.5%	47%
Upto 18 months	NA	12%	38.5%
Upto 24 months	NA	0%	30%
Upto 30 months	NA	NA	8%
Beyond 30 months	NA	NA	0%

2. Automatic Cancellation:

a. *Individual Policy:*

The Policy shall automatically terminate on death of the Insured Person .

b. *Family Floater Policies:*

The Policy shall automatically terminate in the event of the death of all the Insured Persons.

c. *Refund:*

A refund in accordance with the table in Section 5(k)(1) above shall be payable if there is an automatic cancellation of the Policy provided that no claim has been filed under the Policy by or on behalf of any Insured Person.

2. Cancellation by Us:

Without prejudice to the above, We may terminate this Policy during the Policy Period by sending 30 days prior written notice to You address shown in the Schedule of Insurance Certificate without refund of premium if:

i. You or any Insured Person or any person acting on behalf of either has acted in a dishonest or fraudulent manner under or in relation to this Policy;

ii. You or any Insured Person has not disclosed any true , complete and all correct facts in relation to the Policy and/or;

iii. Continuance of the Policy poses a moral hazard.

For avoidance of doubt, it is clarified that no claims shall be admitted and/or paid during the notice period by Us in relation to the Policy.

l. Fraudulent claims

If a claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a claim, or if any fraudulent means or devices are used by the Insured Person or any false or incorrect Disclosure to Information Norms or anyone acting on behalf of the Insured Person to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to Us by all Insured Persons who shall be jointly liable for such repayment.

m. 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.

n. 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 and up to 3 years after the Policy expiration, or until final adjustment (if any) and resolution of all Claims under this Policy.

o. Territorial Jurisdiction

The geographical scope of this Policy applies to events within India other than for Worldwide Emergency Hospitalization and International Treatment for 11 specified Critical Illness. However, all admitted or payable claims shall be settled in India in Indian rupees other than for Worldwide Emergency Hospitalization and International Treatment for 11 specified Critical Illness.

p. 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.

q. Loading/Co-payment

We shall apply a risk loading on the premium payable or Co-payment for certain specific conditions as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Schedule of Insurance Certificate. The maximum risk loading applicable shall not exceed 250% per diagnosis / medical condition and an overall risk loading of 250% per person. These loadings are applied from the inception of the initial Policy including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured). The maximum risk Co-payment shall not exceed 30% per diagnosis/medical condition and an overall risk co-payment of 30% per person.

We will inform You about the applicable risk loading or Co-payment through post/courier/email/phone. You shall revert to Us with your written consent and additional premium (if any), within 15 days of the issuance of such counter offer. In case, You neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within the next 15 days.

r. Portability Benefit

You can port Your existing health insurance policy from another company or from existing product of Royal Sundaram to Lifeline, provided that:

i. You have been covered under an Indian retail health insurance policy from a Non-life/Stand Alone Health insurance company registered with IRDA without any break.
ii. We should have received Your application for Portability with complete documentation at least 45 days before the expiry of Your present period of insurance.
iii. If the Sum Insured under the previous Policy is higher than the Sum Insured chosen under this Policy, the applicable waiting periods under Section 4(a), 4(b), 4(c), 4(d) and 4(e) shall be reduced by the number of months of continuous coverage under such health insurance policy with the previous insurer to the extent of the Sum Insured and the eligible Cumulative Bonus under the expiring health insurance policy.
iv. In case the proposed Sum Insured opted for under Our Policy is more than the insurance cover under the previous policy, then all applicable waiting periods under Section 4(a), 4(b), 4(c), 4(d) and 4(e) and shall be applicable afresh to the amount by which the Sum Insured under this Policy exceed the total of Sum Insured and eligible Cumulative Bonus under the expiring health insurance policy.
v. All waiting periods under Section 4(a), 4(b), 4(c), 4(d) and 4(e) shall be applicable individually for each Insured Person and claims shall be assessed accordingly.
vi. If You were covered on a floater basis under the expiring Policy and apply for a floater cover under this Policy, then the eligible Cumulative Bonus to be carried forward on this Policy shall also be available on a floater basis.
vii. If You were covered on an individual basis in the expiring Policy then the eligible Cumulative Bonus to be carried forward on this Policy shall be available on an individual basis.

For the purpose of this provision, eligible Cumulative Bonus shall mean the Cumulative Bonus which You or the Insured Person would have been eligible for had the same policy been Renewed with the existing insurance company.

It is further agreed and understood that:

i. Portability benefit will be offered to the extent of sum of previous Sum Insured and accrued Cumulative Bonus (if opted for), and Portability shall not apply to any other additional increased Sum Insured.
ii. We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion.
iii. There is no obligation on Us to insure all Insured Persons on the proposed terms, even if You have given Us all documentation.
iv. We should have received the database and claim history from the previous insurance company for Your previous policy.

The Portability provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals.

In case You have opted to switch to any other insurer under portability provisions and the outcome of acceptance of the portability request is awaited from the new insurer on the date of renewal:

i. We may upon Your request extend this Policy for a period of not less than one month at an additional premium to be paid on a pro-rata basis.
ii. If during this extension period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received. Alternatively, We may deduct the premium for the balance period and pay the balance claim amount if any and issue the Policy for the remaining period.

s. Renewal of Policy

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 Renewal premium payable under the Policy provided that revision to the Renewal premium are in accordance with the IRDA 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 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. Coverage is not available for the period for which premium is not received by Us and We shall not be liable for any Claims incurred during such period. The provision of Section 64VB of the Insurance Act shall be applicable.

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 variant/coverage, addition/deletion of members, addition/deletion of Medical Conditions, request at the time of Renewal of the Policy. We reserve Our right in relation to acceptance of the request for changes on Renewal. 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 IRDA. 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 IRDA. 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.

vii. 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 on the Policy will stay with the floater policy.

t. 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 received any motice 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.

u. Grievance Redressal

In case the Insured Person is aggrieved in any way, the Insured Person may contact Us for following grievances:

i. Any partial or total repudiation of claims by the Company.

ii. Any dispute regard to premium paid or payable in terms of the policy.

iii. Any dispute on the legal construction of the policies in *so* far as such disputes relate to claims.

iv. Delay in settlement of claims.

v. Non-issue of any insurance document to customer after receipt of the premium.

vi. Any other grievance.

You / Insured Person may contact Us with the details of the grievance through:

Our website: www.royalsundaram.in

Email: customer.services@royalsundaram.in

Call us at : 18604250000

Fax: 91-44-7113 7114

Courier: Any of Our Branch office or corporate office during business hours

In case You/Insured Person are not satisfied with the decision of the above office, or have not received any response within 10 days, You/Insured Person may contact the official for resolution on:

The Grievance Redressal Unit

Royal Sundaram General Insurance Company Ltd.

Vishranthi Melaram Towers,

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

Karapakkam, Chennai - 600097

Email: grievance.redressal@royalsundaram.in

In case You/Insured Person are not satisfied with Our decision/resolution, You may approach the Insurance Ombudsman at the addresses given in Annexure I.

v. Nominee

You are mandatorily 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.

Any change of nomination shall be communicated to Us in writing and such change shall be effective only when an endorsement on the Policy is made by Us.

In case of any Insured Person other than You under the Policy, for the purpose of payment of claims in the event of death, the default nominee would be You.

w. 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.

x. Complete Discharge

We will not be bound to take notice or be affected by any Notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to You/Insured Person or to Your Nominee/Legal Representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

Annexure I

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Area of Jurisdiction
Ahmedabad	**Shri. P. Ramamoorthy**	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.:- 079-27546150/139 Fax:- 079-27546142 Email:-ins.omb@rediffmail.com	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.
Bhopal		Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Bhopal – 462 023. Tel.:- 0755-2769200/201/202 Fax:- 0755-2769203 Email:-bimalokpalbhopal@gmail.com	States of Madhya Pradesh and Chattisgarh.
Bhubaneshwar	**Shri.B.P. Parija**	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:-ioobbsr@dataone.in	State of Orissa.
Chandigarh	**Shri Manik Sonawane**	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/5861/6468 Fax:- 0172-2708274 Email:-ombchd@yahoo.co.in	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.
Chennai		Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333678/664/668 Fax:- 044-24333664 Email:- chennaiinsuranceombudsman@gmail.com	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).

New Delhi	**Shri Surendra Pal Singh**	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23239611/7539/7532 Fax:- 011-23230858 Email:-iobdelraj@rediffmail.com	States of Delhi and Rajasthan.
Guwahati	**Shri. D.C. Choudhury**	Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2131307/2132205 Fax:- 0361-2732937 Email:- ombudsmanghy@rediffmail.com	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad		Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040-23325325/23312122 Fax:- 040-23376599 Email:-insombudhyd@gmail.com	States of Andhra Pradesh, Karnataka and Union Territory of Yanam - a part of the Union Territory of Pondicherry.
Kochi	**Shri. R. Jyothindranathan**	Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.:- 0484-2358734/759/9338 Fax:- 0484-2359336 Email:- iokochi@asianetindia.com	State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Pondicherry.
Kolkata	**Ms.Manika Datta**	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, KOLKATA - 700 072. TEL : 033-22124346/22124339 Fax : 033-22124341 Email:-insombudsmankolkata@gmail.com	States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.
Lucknow	**Shri. G.B. Pande**	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2201188/31330/1 Fax:- 0522-2231310 Email:-insombudsman@rediffmail.com	States of Uttar Pradesh and Uttaranchal.

Mumbai		Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022-26106928/360/6552/6960 Fax:- 022-26106052 Email:- ombudsmanmumbai@gmail.com	States of Maharashtra and Goa.

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Smt. Rita Bhattacharya, Secretary General
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
MUMBAI – 400 021
Tel : 022-26106245
Fax : 022-26106949
Email- inscoun@gmail.com

Shri D V Dixit, Dy. Secretary
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz (W),
MUMBAI – 400 021.
Tel : 022-26106980
Fax : 022-26106949

Annexure II

List of Generally excluded in Hospitalization Policy		
SNO	**List of Expenses Generally Excluded ("Non-Medical")in Hospital Indemnity Policy -**	**Suggestions**
TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS		
1	Hair Removal Cream	Not Payable
2	Baby Charges (Unless Specified/Indicated)	Not Payable
3	Baby Food	Not Payable
4	Baby Utilities Charges	Not Payable
5	Baby Set	Not Payable
6	Baby Bottles	Not Payable
7	Brush	Not Payable
8	Cosy Towel	Not Payable
9	Hand Wash	Not Payable
10	Moissturiser Paste Brush	Not Payable
11	Powder	Not Payable
12	Razor	Payable
13	Shoe Cover	Not Payable
14	Beauty Services	Not Payable
15	Belts/ Braces	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	Buds	Not Payable
17	Barber Charges	Not Payable
18	Caps	Not Payable
19	Cold Pack/Hot Pack	Not Payable
20	Carry Bags	Not Payable
21	Cradle Charges	Not Payable
22	Comb	Not Payable
23	Disposables Razors Charges (For Site Preparations)	Payable
24	Eau-De-Cologne / Room Freshners	Not Payable
25	Eye Pad	Not Payable
26	Eye Sheild	Not Payable
27	Email / Internet Charges	Not Payable
28	Food Charges (Other Than Patient's Diet Provided By Hospital)	Not Payable
29	Foot Cover	Not Payable
30	Gown	Not Payable

31	Leggings	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	Laundry Charges	Not Payable
33	Mineral Water	Not Payable
34	Oil Charges	Not Payable
35	Sanitary Pad	Not Payable
36	Slippers	Not Payable
37	Telephone Charges	Not Payable
38	Tissue Paper	Not Payable
39	Tooth Paste	Not Payable
40	Tooth Brush	Not Payable
41	Guest Services	Not Payable
42	Bed Pan	Not Payable
43	Bed Under Pad Charges	Not Payable
44	Camera Cover	Not Payable
45	Cliniplast	Not Payable
46	Crepe Bandage	Not Payable/ Payable by the patient
47	Curapore	Not Payable
48	Diaper Of Any Type	Not Payable
49	DVD, CD Charges	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	Eyelet Collar	Not Payable
51	Face Mask	Not Payable
52	Flexi Mask	Not Payable
53	Gause Soft	Not Payable
54	Gauze	Not Payable
55	Hand Holder	Not Payable
56	Hansaplast/Adhesive Bandages	Not Payable
57	Infant Food	Not Payable
58	Slings	Reasonable costs for one sling in case of upper arm fractures should be considered
Items Specifically Excluded In The Policies		
59	Weight Control Programs/ Supplies/ Services	Exclusion in policy unless otherwise specified
60	Cost Of Spectacles/ Contact Lenses/ Hearing Aids Etc.,	Exclusion in policy unless otherwise specified
61	Dental Treatment Expenses That Do Not Require Hospitalisation	Exclusion in policy unless otherwise specified
62	Hormone Replacement Therapy	Exclusion in policy unless otherwise specified
63	Home Visit Charges	Exclusion in policy unless otherwise specified
64	Infertility/ Subfertility/ Assisted Conception Procedure	Exclusion in policy unless otherwise specified

65	Obesity (Including Morbid Obesity) Treatment If Excluded In Policy	Exclusion in policy unless otherwise specified
66	Psychiatric & Psychosomatic Disorders	Exclusion in policy unless otherwise specified
67	Corrective Surgery For Refractive Error	Exclusion in policy unless otherwise specified
68	Treatment Of Sexually Transmitted Diseases	Exclusion in policy unless otherwise specified
69	Donor Screening Charges	Exclusion in policy unless otherwise specified
70	Admission/Registration Charges	Exclusion in policy unless otherwise specified
71	Hospitalisation For Evaluation/ Diagnostic Purpose	Exclusion in policy unless otherwise specified
72	Expenses For Investigation/ Treatment Irrelevant To The Disease For Which Admitted Or Diagnosed	Not payable - Exclusion in policy unless otherwise specified
73	Any Expenses When The Patient Is Diagnosed With Retro Virus + Or Suffering From /HIV/ AIDS Etc Is Detected/ Directly Or Indirectly	Not payable as per HIV/AIDS exclusion
74	Stem Cell Implantation/ Surgery And Storage	Not Payable except Bone Marrow Transplantation where covered by policy
Items Which Form Part Of Hospital Services Where Separate Consumables Are Not Payable But The Service Is		
75	Ward And Theatre Booking Charges	Payable under OT Charges, not payable separately
76	Arthroscopy & Endoscopy Instruments	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	Microscope Cover	Payable under OT Charges, not payable separately
78	Surgical Blades, Harmonic Scalpel, Shaver	Payable under OT Charges, not payable separately
79	Surgical Drill	Payable under OT Charges, not payable separately
80	Eye Kit	Payable under OT Charges, not payable separately
81	Eye Drape	Payable under OT Charges, not payable separately
82	X-Ray Film	Payable under Radiology Charge s, not as consumable
83	Sputum Cup	Payable under Investigation Charges, not as consumable
84	Boyles Apparatus Charges	Part of OT Charges, not seperately
85	Blood Grouping And Cross Matching Of Donors Samples	Part of Cost of Blood, not payable

86	Antiseptic Or Disinfectant Lotions	Not Payable -Part of Dressing Charges
87	Band Aids, Bandages, Sterlile Injections, Needles, Syringes	Not Payable -Part of Dressing Charges
88	Cotton	Not Payable -Part of Dressing Charges
89	Cotton Bandage	Not Payable -Part of Dressing Charges
90	Micropore/ Surgical Tape	Not Payable-Payable by the patien t when prescribed , otherwise included as Dressing Charges
91	Blade	Not Payable
92	Apron	Not Payable -Part of Hospital Services/Disposable linen to be part of OT/ICU charges
93	Torniquet	Not Payable (service is cha rged by hospitals,consumables can not be separate ly charged)
94	Orthobundle, Gynaec Bundle	Part of Dressing Charges
95	Urine Container	Not Payable
Elements Of Room Charge		
96	Luxury Tax	Actual tax levied by government is payable .Part of room charge for sublimits
97	HVAC	Part of room charge not payable separately
98	House Keeping Charges	Part of room charge not payable separately
99	Service Charges Where Nursing Charge Also Charged	Part of room charge not payable separately
100	Television & Air Conditioner Charges	Payable under room charges not if separately levied
101	Surcharges	Part of room charge not payable separately
102	Attendant Charges	Not Payable - P art of Room Charges
103	IM/IV Injection Charges	Part of nursing charges, not payable
104	Clean Sheet ^	Part of Laundry/Housekeeping not payable separately
105	Extra Diet Of Patient(Other Than That Which Forms Part Of Bed Charge)	Patient Diet provided by hospital is payable
106	Blanket/Warmer Blanket Administrative Or Non-Medical Charges	Not Payable- part of room charges
107	Admission Kit	Not Payable
108	Birth Certificate	Not Payable
109	Blood Reservation Charges And Ante Natal Booking Charges	Not Payable
110	Certificate Charges	Not Payable
111	Courier Charges	Not Payable
112	Convenyance Charges	Not Payable
113	Diabetic Chart Charges	Not Payable
114	Documentation Charges / Administrative Expenses	Not Payable

115	Discharge Procedure Charges	Not Payable
116	Daily Chart Charges	Not Payable
117	Entrance Pass / Visitors Pass Charges	Not Payable
118	Expenses Related To Prescription On Discharge	To be claimed by patient under Post Hosp where admissible
119	File Opening Charges	Not Payable
120	Incidental Expenses / Misc. Charges (Not Explained)	Not Payable
121	Medical Certificate	Not Payable
122	Maintenance Charges	Not Payable
123	Medical Records	Not Payable
124	Preparation Charges	Not Payable
125	Photocopies Charges	Not Payable
126	Patient Identification Band / Name Tag	Not Payable
127	Washing Charges	Not Payable
128	Medicine Box	Not Payable
129	Mortuary Charges	Payable upto 24 hrs, shifting charges not payable
130	Medico Legal Case Charges (MLC Charges)	Not Payable
External Durable Devices		
131	Walking Aids Charges	Not Payable
132	Bipap Machine	Not Payable
133	Commode	Not Payable
134	CPAP/ CAPD Equipments Device	Not Payable
135	Infusion Pump - Cost Device	Not Payable
136	Oxygen Cylinder (For Usage Outside The Hospital)	Not Payable
137	Pulseoxymeter Charges Device	Not Payable
138	Spacer	Not Payable
139	Spirometre Device	Not Payable
140	Sp0 2prob E	Not Payable
141	Nebulizer Kit	Not Payable
142	Steam Inhaler	Not Payable
143	Armsling	Not Payable
144	Thermometer	Not Payable (paid by patient)
145	Cervical Collar	Not Payable
146	Splint	Not Payable
147	Diabetic Foot Wear	Not Payable
148	Knee Braces (Long/ Short/ Hinged)	Not Payable
149	Knee Immobilizer/Shoulder Immobilizer	Not Payable
150	Lumbosacral Belt	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.

151	Nimbus Bed Or Water Or Air Bed Charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia /quadripiegia for any reason and at reasonable cost of approximately Rs 200/ day
152	Ambulance Collar	Not Payable
153	Ambulance Equipment	Not Payable
154	Microsheild	Not Payable
155	Abdominal Binder	Essential and should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal liver transplant etc.obstruction,
Items Payable If Supported By A Prescription		
156	Betadine \ Hydrogen Peroxide\Spirit\Disinfectants Etc	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	Private Nurses Charges- Special Nursing Charges	Post hospitalization nursing charges not Payable
158	Nutrition Planning Charges - Dietician Charges diet Charges	Patient Diet provided by hospital is payable
159	Sugar Free Tablets	Payable -Sugar free variants of admissable medicines are not excluded
160	Creams Powders Lotions (Toileteries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)	Payable when prescribed
161	Digestion Gels	Payable when prescribed
162	ECG Electrodes	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	Gloves Sterilized Gloves	payable /unsterilized gloves not payable
164	HIV Kit	Payable - payable Preoperative screening
165	Listerine/ Antiseptic Mouthwash	Payable when prescribed
166	Lozenges	Payable when prescribed
167	Mouth Paint	Payable when prescribed
168	Nebulisation Kit	If used during hospitalization is payable reasonably
169	Novarapid	Payable when prescribed
170	Volini Gel/ Analgesic Gel	Payable when prescribed
171	Zytee Gel	Payable when prescribed
172	Vaccination Charges	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PA YA BLE		

173	Ahd	Not Payable - Part of Hospital's internal Cost
174	Alcohol Swabes	Not Payable - Part of Hospital's internal Cost
175	Scrub Solution/Sterillium	Not Payable - Part of Hospital's internal Cost
OTHERS		
176	Vaccine Charges For Baby	Payable as per Plan
177	Aesthetic Treatment / Surgery	Not Payable
178	TPA Charges	Not Payable
179	Visco Belt Charges	Not Payable
180	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]	Not Payable
181	Examination Gloves	Not Payable
182	Kidney Tray	Not Payable
183	Mask	Not Payable
184	Ounce Glass	Not Payable
185	Outstation Consultant's/ Surgeon's Fees	Not payable, except for telemedicine consultations where covered by policy
186	186 Oxygen Mask	Not Payable
187	Paper Gloves	Not Payable
188	Pelvic Traction Belt	Should be payable in case of PIVI) requiring traction as this is generally not reused
189	Referal Doctor's Fees	Not Payable
190	Accu Check (Glucometery/ Strips)	Not payable pre-hospitilasation or post hospitalisation / Reports and Charts required / Device not payable
191	Pan Can	Not Payable
192	Sofnet	Not Payable
193	Trolly Cover	Not Payable
194	Urometer, Urine Jug	Not Payable
195	Ambulance	Payable as per Plan
196	Tegaderm / Vasofix Safety	Payable - maximum o f 3 in 48 hrs an d then 1 in 24 hrs
197	Urine Bag P	Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs
198	Softovac	Not Payable
199	Stockings	Essential for case like CABG etc. where it should be paid.

Annexure III

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)