ROYAL SUNDARAM GENERAL INSURANCE CO. LTD

Registered office: No. 21, Patullos Road, Chennai- 600 002
Corporate Office: Vishranthi Melaram Towers, No. 2/319,
Rajiv Gandhi Salai (OMR), Karapakkam, Chennai- 600 097

Part II- Policy Document

Section 1 Terms & Conditions

Preamble Clause- 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).

Section 2 Interpretations & Definitions (Operational Clause)

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 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. AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a) Central or State Government AYUSH Hospital; or
b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion :

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def.4. AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

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

Def. 5 AYUSH Treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def. 6. Break in Policy means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

Def. 7. 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. 8. 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. 9. Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def. 10. 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. 11. 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. 12. Co-payment means a cost-sharing requirement under a health insurance policy that provides that the Policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

Def. 13. Critical Illness means the following:

1. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

2. MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
II. The following are excluded:
i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iv. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

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

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:

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

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

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

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
II. Other causes of neurological damage such as SLE and HIV are excluded.

Def. 14. Cumulative Bonus (No Claim Bonus) means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 15. 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:-

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

Def. 16. Day Care Treatment means 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 out-patient basis is not included in the scope of this definition.

Def. 17. Deductible: Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of

days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Def. 18. **Diagnostic Tests:** Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

Def. 19. **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. 20. **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. 21. **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. 22. **Emergency Care** means management for an Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

Def. 23. **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. 24. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

Def. 25. **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:

i. has Qualified Nursing staff under its employment round the clock;

ii. 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;
iii. has qualified Medical Practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

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

Def. 28. **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. 29. **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. 30. **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. 31. **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:-
1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires your rehabilitation for You or for you to be specifically trained to cope with it
4. it continues indefinitely –

5. it comes back or is likely to come back.

Def. 32. Inpatient means the Insured Person's admission to for treatment in a Hospital for more than 24 hours for a covered event.

Def. 33. 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. 34. 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. 34.Maternity Expenses means—

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. 35. Medical Advice: Any **c**onsultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

Def. 36. 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. 37. Medical Practitioner: A Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy 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. It excludes the treatment by a doctor who is an immediate family member i.e. self, spouse, children and parents)

Def. 38. Medically Necessary Treatment: 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.39 Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Def. 40.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. 41. New Born Baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

Def. 42. 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. 43. Non-Network means any Hospital, Day Care Centre or other provider that is not part of the Network.

Def. 44. 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. 45. 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. 46. Policy Period means the period between the date of commencement and the expiry date specified shown in the Schedule of Insurance Certificate.

Def. 47. 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. 48. **Pre-Existing Disease (PED)**: "Pre-existing disease (PED)" means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

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

Def. 49. 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. 50. 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. 51. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

Def. 52. **Product Benefits Table** means the Product Benefits Table issued by Us and accompanying this Policy and annexures thereto.

Def. 53. **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. 54. **Rehabilitation**: Treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.

Def. 55. **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. 56. **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. 57. **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. 58. **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. 59. **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. 60. **Sum Insured** means the sum shown in the Schedule of Insurance Certificate which represents Our maximum total and cumulative liability for any and all claims under the Policy during the Policy Year.

Def. 61. **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. 62. **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

Def. 63. **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. 64. **We/Our/Us** means Royal Sundaram General Insurance Co. Limited.

Def. 65. "**Specific waiting period**" means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

Def. 66. **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.

Section 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) Treatment Charges
(g) Nursing Charges;
(h) Intravenous fluids, blood transfusion, injection administration charges;
(i) Anesthesia, Blood, Oxygen, Operation theatre charges, surgical appliances;
(j) The cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.

Modern Treatments: The following procedures will be covered (whichever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

a. Uterine Artery Embolization and HIFU

b. Balloon Sinuplasty

c. Deep Brain stimulation

d. Oral chemotherapy

e. Immunotherapy- Monoclonal Antibody to be given as injection

f. Intra vitreal injections

g. Robotic surgeries

h. Stereotactic radio surgeries

i. Bronchical Thermoplasty

j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

k. IONM - (Intra Operative Neuro Monitoring)

l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

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 or Day Care Procedures 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 or post Day Care Procedures 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. Pre and Post Hospitalization Medical Expenses are payable under this benefit. All Day Care Procedures are covered.

3.5 Ambulance Cover

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. Organ donor expenses will be covered within the sum insured for the patient (who is undergoing the transplant)

We will not cover:

(a) Pre-hospitalization or Post-hospitalization Medical Expenses or screening expenses of the donor or any other Medical Expenses as a result of the harvesting from the donor;

(b) Costs directly or indirectly associated with the acquisition of the donor's organ;

(c) Any other medical treatment or complication in respect of donor, consequent to harvesting.

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 claims for Pre-hospitalization Medical Expenses shall be payable, However, Post-hospitalization Medical Expenses shall not be payable.

3.8 No Claim Bonus

We will increase Your Sum Insured by 10% of Base Sum Insured per Policy Year upto a maximum of 50% of Base Sum Insured of renewed Policy for Classic Plan and 20% of Base Sum Insured per Policy Year upto a maximum of 100% of Base Sum Insured of renewed Policy for Supreme and Elite plan, if the Policy is renewed with Us provided that there are no claims paid/outstanding in the expiring Policy Year by any Insured Person:

- 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;
- You will not earn No Claim Bonus on Policy Renewal if any claim is made in expiring Policy Year. However, if there is no claim made in subsequent Policy Year, You will earn No Claim Bonus on Renewal as per the plan;
- 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 plan 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 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.

h) Re-load of Sum Insured is applicable only for Baseline Cover benefits and not for optional benefits

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

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

Exclusion 4(D)(16) i.e. Alternative Treatment does not apply to this benefit.

3.11 Vaccination in case of 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 plan– every 2nd consecutive renewal; For Supreme, & Elite, Plan– Available at each renewal. This is available post payment of premium.

iii. This benefit is provided irrespective of any claim being made in the Policy Year.

iv. This benefit is over and above the Base Sum Insured.

3.13 Preventive Healthcare & Wellness and Disease Management

We will provide various preventive healthcare & wellness related activities like health related articles on your registered email ids. Disease Management initiative by us for our existing customers wherein for certain specified Health Risks such as Heart, Kidney, Liver, Cancer, Hypertension, Diabetes etc. our customers will be provided assistance to manage their risk better through preventive check-ups, advise on Nutrition, diet, exercise regime, wearables to monitor various health parameters etc. Any information provided under this will be recommendatory in nature and will not be substitute of doctor consultation.

3.14 Second Opinion for Critical Illness (For Supreme and Elite Plan 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 Plan 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.

vi. This benefit is on per Insured Person basis.

3.16 Worldwide Emergency Hospitalization (excluding US and Canada) (For Elite Plan 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 lakhs;

g) This benefit is available Worldwide excluding US and Canada.

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

i) This benefit is available as cashless facility through pre-authorization by Our Service Provider as well as re-imbursement basis through Us. Process for cashless facility through pre-authorization by Our Service Provider is as mentioned below;

   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 Schedule of Insurance Certificate, 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.

j) It is hereby agreed and understood that pre-authorization under this benefit shall be provided by Service Provider and we shall make our best endeavours to ensure that services are provided in a prompt and efficient manner.

k) Exclusion 4 (D)(36) i.e. Treatment received outside India does not apply to this benefit.

3.17 International Treatment for 11 specified Critical Illness (excluding US and Canada) (For Elite Plan 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) Such Claim in India should have been admissible under the Inpatient Care.

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

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

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

(f) This benefit is available Worldwide excluding US and Canada

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

(h) 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.

(i) 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;

(j) This benefit is available only as cashless facility through pre-authorization by Our Service Provider. Process for cashless facility through pre-authorization by Our Service Provider is as mentioned below;

i. In the event of the diagnosis of a Specified Illness, the Insured Person should call Our Service Provider immediately and in any event before the commencement of the travel for treatment overseas, on the helpline number specified in the Schedule of Insurance Certificate requesting for a pre-authorization for the treatment;
ii. Our Service Provider will evaluate the request and the eligibility of the Insured Person the Policy and call for more information or details, if required.
iii. Our Service Provider will communicate directly to the Hospital and the Insured Person whether the request for pre-authorization has been approved or denied.
iv. 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 or at any Non-Network Hospital shall be borne by the Insured Person.

(k) 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

Exclusion 4 (D) (36) i.e. Treatment received outside India does not apply to this benefit.

3.18 Maternity Benefits (For Elite Plan only)

a. Maternity Benefits

1. We will cover Medical Expenses for the delivery of Insured Person's child subject to the following:

    a. This benefit is available for Insured Person related as legally married husband and wife, where both are covered under the same Family Floater Policy. If a widow is an Insured Person, the benefit under this can be availed only in respect of a pregnancy conceived by her when she and her husband were both covered as Insured Persons during this Policy Period or under the immediately preceding policy with Us;

    b. Our maximum liability per pregnancy Medical Expenses for the same will be subject to the specified subsidiary limit as shown in the Product Benefits Table.

2. We will cover Medical Expenses related to a Medically Necessary termination of pregnancy subject to the conditions mentioned above.

3. The benefits mentioned above shall be claimed maximum twice during Your lifetime.

4. The following expenses are not covered under Maternity Benefit:

    a. Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses;

    b. Medical Expenses for ectopic pregnancy which are covered under the In-patient benefit.

5. We will not cover any claim under Maternity Benefit during the first 36 months of the coverage of the Insured Person who has given birth to the child

6. In case, customer is porting from any other policy providing maternity benefit, the respective waiting period served in that policy will be considered as waiting period waiver in Lifeline policy as per portability guideline.

b. New Born Cover

If we have accepted a Maternity Benefits claim as mentioned above, then We will cover:

a. Medical Expenses towards the medical treatment of the Insured Person's new born baby while the Insured Person is Hospitalized as an In-patient for delivery.

b. Cover the new born baby as an Insured Person until the expiry date of the Policy Year without the payment of any additional premium.

c. Vaccination for New Born Baby – We will cover Reasonable and Customary Charges for vaccination expenses of the New Born Baby for the vaccinations shown in the Product Benefits Table until the new born baby completes one year. If the Policy Period ends before the New Born Baby has completed one year, then, We will only cover such vaccinations until the baby completes one year, provided that We have accepted the baby as an Insured Person at the time of renewal of the Policy.

3.19 OPD Treatment (For Elite Plan Only)

We will cover an Insured Person's Reasonable & Customary Charges for Medically Necessary consultation with a Medical Practitioner, as an OPD Treatment to assess the Insured Person's health condition for any Illness. We will also pay for any Diagnostic Tests prescribed by the Medical Practitioner and medicines purchased under and supported with a Medical Practitioner's prescription upto the sub-limits shown in the Product Benefits Table.

We will also cover the Reasonable & Customary Charges for Dental Treatment, Cost of Spectacles, Contact Lenses and Hearing Aids once in 2 years with a sublimit of 30% of OPD Treatment sublimit shown in the Product Benefits Table.

Section 4 Exclusions

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

4A. Exclusion Name: Pre-Existing Diseases - Code- Excl01

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months (in case of Classic and Supreme) and 24 months (in case of Elite) of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months (in case of Classic and Supreme) and 24 months (in case of Elite) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

4B. Exclusion Name: Specified disease/procedure waiting period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures is as under:
    a) Cataract
    b) Stones in biliary and urinary systems
    c) Hernia / Hydrocele
    d) Hysterectomy for any benign disorder
    e) Lumps / cysts / nodules / polyps / internal tumours
    f) Gastric and Duodenal Ulcers
    g) Surgery on tonsils / adenoids
    h) Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
    i) Fissure / Fistula / Haemorrhoid
    j) Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
    k) Benign Prostatic Hypertrophy

l) Knee/Hip Joint replacement
m) Dilatation and Curettage
n) Varicose veins
o) Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
p) Chronic Renal Failure or end stage Renal Failure

4C. 30-day waiting period- Code- Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4D. Exclusions The company shall not be liable to make any payment under the policy in respect of any expenses incurred in connection with or in respect of :

1. **Investigation & Evaluation- Code- Excl04**
a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. Rest Cure, rehabilitation and respite care- Code- Excl05
a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. Obesity/ Weight Control: Code- Excl06
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: Code- Excl07

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

5. Cosmetic or plastic Surgery: Code- Excl08

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

6. Hazardous or Adventure sports: Code- Excl09

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

7. Breach of law: Code- Excl10

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

8. Excluded Providers: Code- Excl11

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

9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12

10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code- Excl13

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

12. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

This exclusion does not apply for OPD Treatment (Section 3.19) under Elite Plan.

13. Unproven Treatments: Code- Excl16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. Sterility and Infertility: Code- Excl17

Expenses related to Sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

15. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

This exclusion does not apply to Elite Plan.

16. Alternative treatment Code Excl19

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

17. Ancillary Hospital Charges Code Excl20

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

18. Charges for medical papers Code Excl21

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.

19. Circumcision Code Excl22

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

20. Conflict and disaster Code Excl23

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

21 Congenital conditions Code Excl24

Treatment for any External Congenital Anomaly.

22. Convalescence and Rehabilitation Code Excl25

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.

23.Dental/oral treatment Code Excl26

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.

This exclusion does not apply for OPD Treatment (Section 3.19) under Elite Plan.

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.

24.Drugs and dressings for OPD Treatment or take-home use Code **Excl27**

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. This exclusion does not apply for OPD Treatment (Section 3.19) under Elite Plan

25. Hereditary conditions (Specified) Code **Excl28**

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.

26. Items of personal comfort and convenience, including but not limited to: Code **Excl29**

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.

27.OPD Treatment Code **Excl30**

OPD Treatment is not covered.

However, this exclusion does not apply for:

a. Vaccination in case of Animal Bite (Section 3.11)

b. OPD Treatment (Section 3.19) (available only in case of Elite plan)

c. Vaccination for New Born Baby (Section 3.18 (c) (available only in case of Elite plan)

28. Preventive Care Code **Excl31**

All preventive care, vaccination including inoculation and immunisations except in case of

a. Vaccination in case of Animal Bite (Section 3.11)

d. Vaccination for New Born Baby (Section 3.18 (c)) (available only in case of Elite plan)

29. Self-inflicted injuries Code **Excl32**

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

30.Sexual problems Code **Excl33**

Treatment of any sexual problem including impotence (irrespective of the cause) or erectile dysfunction.

31.Sexually transmitted diseases Code **Excl 34**

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

32. Sleep disorders Code **Excl35**

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

33. Treatment for Alopecia Code **Excl 36**

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

34. Treatment for developmental problems Code **Excl 37**

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

A. including attention deficit hyperactivity disorder (ADHD);
B. deviated nasal septum (correction of deviation of nasal septum for cosmetic purpose)

35. Treatment received outside India Code **Excl38**

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).

36. Artificial Life maintenance is not covered from the time Insured Person goes into vegetative state and a point of no recovery to Life. Code Excl39

37. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion: Code Excl40

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing ant illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing ant illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

4E. 90 days Initial Waiting Period for Critical Illness Code Excl41

We will not cover any treatment for critical illness symptoms of which first occur or manifest itself during the first 90 days since the date of commencement of the policy.

4F. Personal Waiting Periods Code Excl 42

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

4G. The expenses that are not covered in this policy are placed under List-I of Annexure-I.

4H. Moratorium Period: After completion of five continuous years under this policy no look back would be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the Sum Insured of the first policy and subsequently completion of five continuous years would be applicable from the date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

4I. In case of non-disclosure of a condition, we can incorporate additional waiting period of not exceeding 36 months for the said undisclosed disease or condition from the date the un-disclosed condition was detected and continue with the policy subject to obtaining prior consent from you or Insured Person.

4J. Where the non-disclosed condition allows us to continue the coverage by levying extra premium or loading based on the objective criteria laid down in the Board approved underwriting policy, we shall levy the same prospectively from the date of noticing the non-disclosed condition. However, in respect of policy contracts for a duration exceeding one year, If the un-disclosed condition is surfaced before the expiry of the policy term, we may charge the extra premium or loading retrospectively from the first year of issuance of the policy or renewal, whichever is later.

Section 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. Cashless Claims will be settled through TPA and Re-imbursement Claims will be settled by Us. The Claims Procedure is as follows:

a) For admission in Network Hospital (Cashless Claims) (For Domestic Claims only)

Insured Person shall call the TPA helpline and furnish Membership Number, Policy Number and the Name of the Patient within 72 hours before admission to hospital for planned hospitalization and not later than 48 hours of admission in case of emergency hospitalization. The insured shall also provide to the TPA by e-mail or through TPA's web portal, the details of hospitalization like diagnosis, name of hospital, duration of stay in hospital, estimated expenses of hospitalization etc. in the prescribed form available with the Insurance help desk at the Hospital. The Insured shall also provide any additional information or medical record as may be required by the medical panel of the TPA. After establishing the admissibility of the claim under the policy, the TPA shall provide a pre-authorisation to the hospital guaranteeing payment of the hospitalization expenses subject to the sum insured, terms conditions and limitations of the policy. The difference between the amount of pre-authorisation approved and the final hospital bill owing to deductions such as non-payable items, excluded items, policy sub-limits, copay amount, deductible amt etc, shall be borne by the insured.

b) For admission in Non-Network Hospital or into Network Hospital if cashless facility is not availed (Re-imbursement Claims) (For Domestic Claims as well as Worldwide Emergency Hospitalization)

- **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. Discharge summary (detailed) describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.
2. Death summary in case of death of the insured person at the hospital.
3. First consultation papers
4. Doctor's prescriptions confirming diagnosis/advising hospitalization
5. All test reports such as X-rays, ECG, Scan, MRI, Pathology etc, including doctor's prescription advising such tests/investigations (CDs of angiogram, surgery etc need not be sent unless specifically sought).
6. Hospital Final Bill and advance and final hospital payment receipts, in Original.
7. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital.
8. F.I.R/MLC. in the case of accidental injury and English translation of the same, if in vernacular language.
9. Detailed self-description stating the date, time, circumstances and nature of injury/accident in case of claims arising out of injury (in the absence of FIR)
10. 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.
11. For a) maternity claims, Discharge Summary mentioning LMP, EDD & Gravida b)Cataract claims - IOL sticker c) PTCA claims - Stent sticker. d) Implant sticker for surgeries involving implants
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. Complete medical records of past hospitalization/treatment, if any.
14. 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.
15. For OPD claims and Vaccination Animal Bite claims – Bills/Receipts and doctor's prescription advising the same
16. 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
17. For Worldwide Emergency Hospitalization and International Treatment for specified Critical Illness – Insured Person/Attendants -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. 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 specified Critical Illness.
- Benefits payable under this policy will be paid within 15 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. 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.

Section 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 Our liability under the Policy that the Policyholder shall immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business at his own expense (refer Annexure II). 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. 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.

f. 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.

g. Change of Policyholder

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

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

h. 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.

i. Free Look Provision

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

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

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

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

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

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

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

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

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

The Company shall:

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

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

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

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

k. 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.

l. 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.

m. Records to be maintained

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

n. Territorial Jurisdiction

The geographical scope of this Policy applies to events within India other than for Worldwide Emergency Hospitalization and International Treatment for 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 specified Critical Illness.

o. 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.

p. 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 150% per diagnosis / medical condition and an overall risk loading of 200%. 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%.

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.

q. Migration:

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

i. The waiting periods specified in Section 4 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.

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

For Detailed Guidelines on Migration, kindly refer the below link:-
https://www.royalsundaram.in/html/files/Modification-guidelines-on-standardization-in-health-insurance-Migration.pdf

r. Portability Benefit

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

i. The waiting periods specified in Section 4 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.

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

iii. We should have received Your application for Portability with complete documentation at least 45 days before the expiry of Your present period of insurance.
iv. If the Sum Insured under the previous Policy is higher than the Sum Insured chosen under this Policy, the applicable waiting periods under Section 4A to 4I, 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.
v. 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 4A to 4I 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.
vi. All waiting periods under Section 4A to 4I shall be applicable individually for each Insured Person and claims shall be assessed accordingly.
vii. 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.
viii. 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.

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

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

iii. The premium payable on renewal shall be paid to Us on or before the Policy Period End Date and in any event before the expiry of the **Grace Period**. For the purpose of this provision, Grace Period means a period of 15 days in case of monthly payments and 30 days in case of quarterly, half-yearly and yearly payments 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. If the premium is paid in instalments, coverage will still be available during the grace period,

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

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

vi. This product may be withdrawn by Us after due approval from the IRDAI. In case this product is withdrawn by Us, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDAI. We shall duly intimate You regarding the withdrawal of this product and the options available to You at the time of Renewal of this Policy.

In case of floater policies, children attaining 25 years at the time of renewal will be moved out of the floater into an individual cover however all continuity benefits on the policy will remain intact. Cumulative Bonus earned will be suitably passed on the fresh policy of child.

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. Multiple Policies

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

v. Premium Payment in Instalment

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of insurance, the following Conditions shall apply (not withstanding any terms contrary elsewhere in the Policy)
1) In case of monthly mode of premium payment, grace period of 15 days is allowed and would be given maximum two times in a policy period. In case of quarterly and half-yearly and yearly mode of premium payment, grace period will be allowed maximum only once for a period of 30 days for payment of the instalment premium due for the policy.
2) If the premium is paid in instalments, coverage will still be available during the grace period.
3) The Benefits provided under — “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of premium within the stipulated grace Period.
4) No interest will be charged if the instalment premium is not paid on due date.
5) In case of instalment premium due not received within the grace period, the policy will get cancelled.
6) ln the event of a claim, all subsequent premium instalments shall immediately become due and payable. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

w. Grievance Redressal

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

Website: https://www.royalsundaram.in

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

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

Email:

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

4. In case you are not happy with our response or have not received any response in 2 business days, you may approach gro@royalsundaram.in - GRO Contact Number – 7228087400

Sr. Citizen can email us at : seniorcitizengrievances@royalsundaram.in - Senior Citizen Grievance Number - 7228933501 (A separate e-mail id for Senior Citizens has been created for the ease and convenience of Senior citizens)

Fax us at: 044 – 7117 7140

Courier us your complaint at:

Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers,
No.2/319, Rajiv Gandhi Salai (OMR)
Karapakkam, Chennai – 600097

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

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

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

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

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

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

Grievance may also be lodged at –

Registration of Complaints in Bima Bharosa by Policyholders:

1. Can directly register complaint in the **Bima Bharosa Portal** https://bimabharosa.irdai.gov.in/
2. Can send the complaint through Email to complaints@irdai.gov.in.
3. Can call Toll Free No. **155255** or **1800 4254 732**.
4. Apart from the above options, if it is felt necessary by the complainant to send the communication in physical form, the same may be sent to IRDAI addressed to:

   General Manager

   Insurance Regulatory and Development Authority of India(IRDAI)

Policyholder's Protection & Grievance Redressal Department – Grievance Redressal Cell.
Sy.No.115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500 032.

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

Insurance is the subject matter of solicitation.

x. 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.

y. 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.

z. 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.

Insurance Ombudsman

The contact details of the **Insurance Ombudsman** offices are as below-

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

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Council for Insurance Ombudsmen

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

WHAT IF I EVER NEED TO COMPLAIN?

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

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

Royal Sundaram General Insurance Co. Limited

IRDAI Registration No.102. | CIN: U67200TN2000PLC045611

Annexure I

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

SI No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS

6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES

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

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

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

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

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

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

SI No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD

5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS

7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure II

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)