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

**Part II- Policy Document**

**Policy Terms and Conditions**

**B.1 Preamble**

This Policy is a contract of insurance issued by Royal Sundaram General Insurance Co. Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

**B.2 Operative 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 form 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 (including sub limits, Co-payment if any) and exclusions of the Policy subject to availability of Sum Insured and Cumulative Bonus (if any).

**C Definitions**

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

**C.1 Standard Definitions**

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

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

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

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

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

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.

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

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

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

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

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

a) **Internal Congenital Anomaly**

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

b) **External Congenital Anomaly**

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

**C.1.9** **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

**C.1.10** **No Claim Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

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

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

Company's authorized personnel.

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

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

**C.1.13 Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

**C.1.14 Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

**C.1.15 Domiciliary Hospitalization**

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

i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

ii) the patient takes treatment at home on account of non-availability of room in a hospital.

**C.1.16 Emergency Care:**

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

**C.1.17 Grace Period** "Grace period" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

**C.1.18 Hospital** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

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

**C.1.19 Hospitalization** means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

**C.1.20 Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

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

ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics.

a) It needs ongoing or long-term monitoring through consultations, examinations, check-rips, and / or tests
b) It needs ongoing or long-terns control or relief of symptoms
c) It requires rehabilitation for the patient or for the patient to be special trained to cope with it
d) It continues indefinitely
e) It recurs or is likely to recur

**C.1.21 Injury** means Accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

**C.1.22 In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

**C.1.23 Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

**C.1.24 ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensives charges.

**C.1.25 Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

**C.1.26 Medical Expenses** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

**C.1.27 Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

**C.1.28 Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

**C.1.29 Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

**C.1.30 Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cash less facility.

**C.1.31 Non- Network Provider** means any hospital that is not part of the network.

**C.1.32 Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

**C.1.33 Out-Patient (OPD) Treatment** means treatment in which the insured visits a clinic/ hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.

**C.1.34 Pre-Existing Disease (PED)**: "Pre-existing disease (PED)" means any condition, ailment, injury or disease:
a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

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

**C.1.35 Pre-hospitalization Medical Expenses**

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

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

**C.1.36 Post-hospitalization Medical Expenses**

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

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

**C.1.37 Portability**
"Portability" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

**C.1.38 Qualified Nurse**

Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

**C.1.39 Reasonable and Customary Charges**

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

**C.1.40 Renewal**

Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

**C.1.41 Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

**C.1.42 Specific waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

**C.1.43 Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

**C.1.44 Unproven/Experimental treatment:**

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

**C.1.45 Associate Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or Room Category applicable in Hospital:

(a). Room, boarding, nursing and operation theatre expenses as charged by the Hospital where the Insured Person availed medical treatment.

(b) Fees charged by the surgeon, anaesthetist, Medical Practitioner;

**Note:**

i. The following expenses shall not form part of 'Associate Medical Expenses'.
   - Cost of Pharmacy and Consumables;
   - Cost of implants and medical devices
   - Cost of Diagnostics

ii. Associate Medical Expenses are not applied in respect of the hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category.

## C.2 Specific Definitions

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

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

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

**C.2.4** **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 No Claim 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.

**C.2.5** **Diagnostic Tests:** Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

**C.2.6** **Emergency** means a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

**C.2.7** **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 up to six members who are related to each other in the following manner:

i) Legally married husband and wife as long as they continue to be married; and/or
ii) Up-to four of their children who are less than 25 years on the date of commencement of the cover under the Policy.

**C.2.8** **Re-load means** the restoration of hundred percent of the Base Sum Insured in accordance with Section D.10 (Reload Benefit) of the Policy.

**C.2.9** **Hospitalized** means the admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

**C.2.10** **Individual Policy** means a Policy in terms of which only one person is named in the Schedule of Insurance Certificate as Insured Person.

**C.2.11** **Information Summary Sheet** means the record and confirmation of information provided to Us or Our representatives over the telephone for the purposes of applying for this Policy.

**C.2.12** **Inpatient** means the Insured Person's admission to for treatment in a Hospital for more than 24 hours for a covered event.

**C.2.13** **Insured Person** means person named as insured in the Schedule of Insurance Certificate. Any Family member may be added as an Insured Person during the Policy Period if We have

accepted his application for insurance and issued an endorsement confirming the addition of such person as an Insured Person.

**C.2.14** **Policy** means these terms and conditions, any annexure thereto and the Schedule of Insurance Certificate (as amended from time to time), Your statements in the proposal form and the Information Summary Sheet and the policy wording (including endorsements, if any).

**C.2.15** **Policy Period** means the period between the date of commencement and the expiry date specified shown in the Schedule of Insurance Certificate.

**C.2.16** **Policy Year** means the period of one year commencing on the date of commencement specified in the Schedule of Insurance Certificate or any anniversary thereof.

**C.2.17** **Product Benefits Table** means the Product Benefits Table issued by Us and accompanying this Policy and annexures thereto.

**C.2.18** **Rehabilitation**: Treatment aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.

**C.2.19** **Schedule of Insurance Certificate** means the schedule provided in the insurance certificate issued by Us, and, if more than one, then the latest in time.

**C.2.20** **Sum Insured** means the sum shown in the Schedule of Insurance Certificate which represents Our maximum total and cumulative liability for any and all claims under the Policy during the Policy Year.

**C.2.21** **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

**C.2.22** **We/Our/Us** means Royal Sundaram General Insurance Co. Limited.

**C.2.23** **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously relieved without any break.

**C.2.24** **You/Your/Policyholder** means the person named in the Schedule of Insurance Certificate who has concluded this Policy with Us.

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

## D Benefits Covered Under the Policy

The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken during the Policy Period for an Illness, Accident or condition described below if this is contracted or sustained by an Insured Person during the Policy Period and subject always to the Sum Insured, any sub limit specified in the Product Benefits Table, the terms, conditions, limitations and exclusions, Co-pay (if any) mentioned in the Policy.

**General conditions applicable to all the benefits:**

1. The maximum, total and cumulative liability of the Company in respect of an Insured Person for any and all Claims arising under this Policy during the Policy Year shall not exceed the Sum Insured as mentioned in the policy schedule against that benefit for that Insured Persons.
    a. On Floater Basis, the Company's maximum, total and cumulative liability, for any and all claims incurred during the Policy Year in respect of all Insured Person, shall not exceed the Sum Insured as mentioned in the policy schedule.
    b. For any single Claim during a Policy Year, the maximum Claim amount payable shall be sum total of Sum Insured and No Claim Bonus.

c. All Claims shall be payable subject to the terms, conditions, exclusions, sub-limits and wait period of the Policy and subject to availability of the sum Insured.
d. Benefits will be used in the following sequence:
    i. Base Sum Insured,
    ii. No Claim bonus,
    iii. Reload Benefit

2. Any Claim paid for benefits namely in-patient Care, Modern Treatment, Pre-hospitalisation Expenses, Post Hospitalisation Expenses, Day Care Treatment, Organ Donor Expense, Domiciliary Hospitalisation, AYUSH treatment and Ambulance cover including app based cab cover shall reduce the Sum Insured for the Policy Year and only the balance shall be available for all the future claims for that Policy Year.
3. Admissibility of a Claim under the benefit In-patient Care and/or Day Care Treatment is a pre-condition to the admission of a Claim under Modern Treatment, Pre-Hospitalisation expenses, Post hospitalisation expenses, Organ Donor Expense, Domically Hospitalisation, AYUSH treatment and Ambulance cover including app based cab cover.
4. Child upon attaining age of 25 years or more at the time of renewal would be migrated to a separate policy of company unless eligible as an Adult to be covered under this Policy.

## D.1 In-patient Care

The Company shall indemnify medically necessary expenses incurred through Cashless or Reimbursement facility for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured as specified in the policy schedule, for

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

Under this policy, the insured shall be eligible for a Single Private A/C room. For the purpose of this benefit, Single Private A/C Room means a basic (most economical of all accommodation) category of single room in a Hospital with air-conditioning facility where a single patient is accommodated and which has/does not have an attached toilet (lavatory and/or bath).

The insured person should be hospitalized as an in-patient care for a minimum period of 24 consecutive hours, as prescribed in writing by a Medical Practitioner, to avail of this cover.

### D.1.1 General conditions applicable to Inpatient Care

1. If the insured person is admitted in Hospital room where room category opted or room rent incurred is higher than the eligible room category/room rent as specified in policy schedule, then the insured person shall bear proportionate deduction of total Associate Medical Expenses (including applicable charges and taxes thereon) in proportion of the difference between room rent actually incurred and room rent specified in the policy schedule or entitle room category to actually room rent incurred.
2. Room rent as mentioned in the policy schedule shall apply for the benefit mentioned in section D.1 to D.8.
3. There will be no restriction on ICU charges incurred during the hospitalisation.

**Illustration:**

Mr. Amit has taken a NeXT Gen Health Insurance Policy of 10Lac Sum insured, hence he was eligible for single private A/C Room. During the hospitalisation, he opted for deluxe room which cost is 15,000 per day, while single private A/c room cost in that hospital was 10,000 per day. Now he got the hospital bill of 7.5Lacs.

Break-up of Hospital bill

| S. No. | Type of Expenses | Amount |
|---|---|---|
| 1. | Room Rent (15,000*15 Days) | 2,25,000 |
| 2. | Medical Practitioner's Charges | 60,000 |
| 3. | Investigations | 80,000 |
| 4. | OT, Nursing Charges | 1,30,000 |
| 5. | Medicines | 75,000 |
| 6. | Internal Implant Cost | 1,30,000 |
| 7. | Other Non-Payable Expenses (Non-Payable Items) | 50,000 |
| | **Total Hospital Bill** | **7,50,000** |

**Eligibility of claim**

Proportionate Deduction on account of higher room opted – 33.3%

(100% - 10,0000/15,000)

**Claim Assessment**

| S. No. | Type of Expenses | Amount |
|---|---|---|
| 1. | Room Rent | 1,50,000 |
| 2. | Medical Practitioner's Charges | 40,000 |
| 3. | Investigations | 53,333 |
| 4. | OT, Nursing Charges | 86,667 |
| 5. | Medicines | 75,000 |
| 6. | Internal Implant Cost | 1,30,000 |
| | | |
| | **Amount Eligible for claim** | **5,35,000** |

Proportionate deduction applied on Room rent, Medical Practitioner's Fees, Investigation, OT and nursing. You can refer definition of Associate Medical Expense (Clause C.1.42).

## D.2 Pre-hospitalization Expenses

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care or day care treatment, up to the Sum Insured for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

### D.2.1 General Conditions applicable to this benefit:

1. This benefit will be available on reimbursement basis only.
2. Pre-hospitalization expenses shall be payable only if We have accepted the claim for same Illness/Injury has been accepted under the section 'In patient Care'.

### D.3 Post-hospitalization Expenses

The company shall indemnify Post-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, up to the Sum Insured, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

#### D.3.1 General Conditions applicable to this benefit:

1. This benefit will be available on reimbursement basis only.
2. Post hospitalization expenses shall be payable only if We have accepted the claim for same Illness/Injury has been accepted under the section 'In patient Care'.

### D.4 Modern Treatments

The Company shall indemnify the Insured Person for the expenses incurred under the following procedures either as in patient or as part of day care treatment in a hospital up to the Sum Insured, specified in the policy schedule, during the policy period:

I. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
II. Balloon Sinuplasty
III. Deep Brain stimulation
IV. Oral chemotherapy
V. Immunotherapy - Monoclonal Antibody to be given as injection
VI. Intra vitreal injection
VII. Robotic surgeries
VIII. Stereotactic radio surgeries
IX. Bronchical Thermoplastic
X. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
XI. IONM - (Intra Operative Neuro Monitoring)
XII. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

### D.5 Day Care Treatment

The company shall indemnify Medical Expenses of an Insured Person, through Cashless or Reimbursement facility, incurred on Day Care Treatment or Surgery where the period of treatment does not exceed 24 hours Hospitalization due to advancement in technology and which is undertaken in a Hospital/Day Care Centre on the written recommendation of a Medical Practitioner. Any OPD Treatment undertaken in a Hospital/Day Care Centre will not be covered.

### D.6 Organ Donor Expenses

The Company shall indemnify the Insured Person, through Cashless or Reimbursement Facility for Inpatient Care Medical Expenses towards the organ donor for the harvesting of the organ donated provided that:

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

**D.6.1 We will not cover:**

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

## D.7 Domiciliary Hospitalization

The Company shall indemnify the Medical Expenses incurred on Insured Person's Domiciliary Hospitalization, subject to fulfilment of following conditions:

(i) If Domiciliary Hospitalization continues for an uninterrupted period of 3 days;
(ii) the condition for which treatment is taken would otherwise have necessitated Hospitalization;
(iii) the attending Medical Practitioner confirms that the Insured Person could not be transferred to a Hospital; or
(iv) the Insured Person satisfies Us that a Hospital bed was unavailable.

If a claim has been accepted under this Benefit, the claims for Pre and Post-hospitalization Medical Expenses are payable up to 30 days and 60 days respectively under this benefit.

**D.7.1 General Conditions applicable to this benefit:**

1. This cover will be available on reimbursement basis only.
2. It excludes the coverage of geriatric related conditions.
3. The following medical conditions will be excluded from this cover:
   (i) Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
   (ii) Arthritis, Gout and Rheumatism
   (iii) Chronic Nephritis and Nephritic Syndrome
   (iv) Diarrhoea and all type of Dysenteries including Gastroenteritis,
   (v) Diabetes Mellitus and Insipidus,
   (vi) Epilepsy,
   (vii) Hypertension,
   (viii) Pyrexia of unknown origin,
   (ix) All Psychiatric or psychosomatic Disorders.

## D.8 AYUSH Treatment

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

## D.9 Ambulance Cover including App-based Cab cover

The Company shall indemnify ambulance expenses that are incurred towards transportation of an Insured Person by surface transport, following an Emergency to the nearest Hospital with adequate facilities.

The Company will also cover charges for app based cabs service incurred towards transportation of an Insured Person at the time of getting admitted to the Hospital. This cover is available only on reimbursement basis. For availing this cover through App-based Cab services, submission

of an invoice generated by a digital app based cab service is mandatory. The invoice should mention following details

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

These charges are payable only if we have accepted a Hospitalization claim under the provisions of Section D.1 above. Benefit under this cover is payable maximum up to the limits specified in the Certificate of Insurance or Part 1 of the Policy Schedule or Product Benefits Table.

**D.10 Reload Benefit**

We will Reload Your Sum Insured, once in a Policy Year, up to 100% of Base Sum Insured, subject to the following:

1. the Base Sum Insured and No Claim Bonus (if any) is insufficient as a result of previous claims in that Policy Year;
2. Reload benefit shall not apply to the first claim in the Policy Year;
3. Reload benefit once triggered can be used for the illness (including Complications) other than for which a claim has been paid or accepted for same insured in a Policy Year.
4. If the policy is issued on a floater basis, the Reload Sum Insured will also be available on floater basis;
5. If the Reload Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year;
6. Reload Benefit can be utilised on D.1 inpatient Care, D.2 Pre-hospitalization Expenses, D.3 Post Hospitalization Expenses, D.4 Modern Treatment, D.5 Day Care Treatment, D.6 Organ Donor Expense, D.7 Domiciliary Treatment and D.8 AYUSH Treatment.

**D.11 No Claim Bonus**

We will increase Your Sum Insured by 10% of Base Sum Insured per Policy Year up to a maximum of 50% of expiring Base Sum Insured, if the Policy is renewed with Us and provided that there are no claims paid/outstanding in the expiring Policy Year by any Insured Person.

**Above coverage is subject to the following conditions:**

1. 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;
2. No Claim Bonus shall be calculated based on Base Sum insured of expiring Policy Year;
3. Any earned No Claim Bonus will be reduced at the same rate as it was accrued in immediate succeeding Policy Year to the Policy Year in which claim was made. However, in any case No Claim Bonus cannot be less than zero.
4. If two or more Individual Policies 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:
5. 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;
6. If the Insured persons in the expiring policy are covered on a family floater policy and such Insured Persons renew their expiring Policy with Us by splitting the Floater Sum Insured stated in the Policy Schedule in to two or more floater / individual Policy, then We will provide the credit of the accumulated Cumulative Bonus to each of the split Policy in

proportion of allocated new sum insured in each policy to the sum insured in expiring policy;

7. In case the Base Sum Insured under the Policy is reduced at the time of Renewal, the applicable accumulated Cumulative Bonus shall also be reduced in proportion to the renewed Base Sum Insured;
8. No Claim Bonus shall be applicable on an annual basis subject to the continuation of the Policy;
9. 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.
10. Any additional Sum insured such as Reload Benefit shall not be used in the computation of No Claim Bonus.

**Illustration of No Claim Bonus**

| Policy Year | Sum Insured Opted | No claim Bonus | Claim Amount |
|---|---|---|---|
| 1 | 10,00,000 | Nil | |
| 2 | 10,00,000 | 1,00,000 | |
| 3 | 10,00,000 | 2,00,000 | |
| 4 | 25,00,000 | 3,00,000 | |
| 5 | 25,00,000 | 5,50,000 | |
| 6 | 25,00,000 | 8,00,000 | 5,00,000 |
| 7 | 25,00,000 | 5,50,000 | |
| 8 | 10,00,000 | 3,20,000 | |

## D.12 Annual Health Check-up

The Company will arrange for a health check-up as per Your 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 the Insured Person who is covered under the Policy as the Policyholder's child;
ii. This Benefit is available once in every policy year starting 1st inception of the policy with us.
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.

| List of Medical Test covered |
|---|
| Complete Blood Count, Urine Routine, ESR, HBa1C, Lipid Profile, Kidney Function Test, ECG, Complete physical examination be Physician |

Abbreviation of test is provided here:

ESR – Erythrocyte Sedimentation Rate, ECG – Electrocardiogram, HbA1C – Glycosylated Haemoglobin Test

## E Exclusions

### E.1 Standard Exclusions

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

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

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

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

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

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

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. The exclusion shall not be applicable for claims arising due to an Accident.
b) ln case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures is as under:
    a) Cataract
    b) Stones in biliary and urinary systems
    c) Hernia / Hydrocele
    d) Hysterectomy for any benign disorder

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

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

**E.1.4 Investigation & Evaluation (Code- Excl04)**

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

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

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

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

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

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

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

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

**E.1.8 Cosmetic or plastic Surgery: (Code- Excl08)**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

**E.1.9 Hazardous or Adventure sports: (Code- ExcI09)**
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

**E.1.10 Breach of law: (Code- Excl10)**
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

**E.1.11 Excluded Providers: (Code-Excl11)**
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded but the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threating situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

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

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

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

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

**E.1.18 Maternity Expenses (Code – Excl18)**:
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

## E.2 Specific Exclusions

### E.2.1 Personal Waiting Periods

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

### E.2.2 Alternative treatment

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

### E.2.3 Circumcision

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

### E.2.4 Conflict and disaster

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

**a.** The Insured Person put himself in danger by entering a known area of conflict where active fighting or insurrections are taking place.
**b.** The Insured Person was an active participant in the above mentioned acts or events of a similar nature.
**c.** The Insured Person displayed a blatant disregard for personal safety

### E.2.5 Congenital conditions

Treatment for any External Congenital Anomaly.

### E.2.6 Convalescence and Rehabilitation

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

a. Convalescence, rehabilitation, supervision or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in Hospital.
b. receiving general nursing care or any other services that do not require the Insured Person to be in Hospital and could be provided in another establishment that is not a Hospital
c. receiving services from a therapist or complementary medical practitioner or a practitioner of Alternative Treatment.

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

Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment, or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-hospitalization expenses under Section D.3 above.

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

A. Telephone, television, diet charges, (unless included in room rent) personal attendant or barber or beauty services, baby food, cosmetics, napkins, toiletry items, guest services and similar incidental expenses or services.
B. Private nursing/attendant's charges incurred during Pre-hospitalization or Post-hospitalization.
C. Drugs or treatment not supported by prescription.

D. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.
E. Any charges incurred to procure any treatment/Illness related documents pertaining to any period of Hospitalization/Illness.
F. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer/thermometer and similar items and also any medical equipment which is subsequently used at home.

**E.2.9 OPD treatment**

Any expenses incurred on OPD treatment

**E.2.10 Preventive Care**

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

**E.2.11 Self-inflicted injuries**

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

**E.2.12 Treatment for Alopecia**

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

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

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

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

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

**E.2.16 Charges for medical papers**

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

**E.2.17** Artificial Life maintenance is not covered from the time Insured Person goes into vegetative state and a point of no recovery to Life.

**E.2.18** The expenses that are not covered in this policy are placed under List-I of Annexure-A.

**E.2.19** Impairment of Person's Intellectual faculties by usage of drugs, stimulants or depressants unless prescribed by a medical practitioner.

## F General Terms & Clauses

### F.1 Standard General Terms and Clauses

#### F.1.1 Disclosure of Information

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

#### F.1.2 Condition Precedent to Admission of Liability

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

#### F.1.3 Claim Settlement (provision for Penal Interest)

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

#### F.1.4 Complete Discharge

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

#### F.1.5 Multiple Policies

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

4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

**F.1.6 Fraud**

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

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

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

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

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

**F.1.7 Cancellation**

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

The Company shall:

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

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

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

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

**F.1.8 Migration**

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any

health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section E shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/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

**F.1.9 Portability**

The insured Person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with the all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI 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, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

https://www.royalsundaram.in/health-insurance/health-insurance-portability

**F.1.10 Renewal of Policy**

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

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 15 days in monthly and 30 days in case of quarterly, half- yearly and yearly payments to maintain continuity of benefits without break in policy. If the premium is paid in instalments, coverage will still be available during the grace period.
iv. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
v. If not renewed with in Grace Period after due renewal date, the Policy shall terminate.

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

**F.1.11 Withdrawal of Policy**

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

**F.1.12 Moratorium Period**

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

**F.1.13 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 instalments from the claim amount due under the policy.

**F.1.14 Possibility of Revision of Terms of the Policy Including the Premium Rates**

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

**F.1.15 Free look period**

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

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

b) where the risk has already commenced and the option of return of the policy is exercised, a deduction towards the proportionate risk premium for period on cover or;
c) Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.
d) Free-look will not be applicable for policies with tenure less than one year.
e) Free-look not applicable in case of renewals.

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

**F.1.16 Redressal of grievance**

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

Website: https://www.royalsundaram.in

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

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

Email:

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

### F.1.17 Nomination

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

## F.2 Specific Terms and Clauses

### F.2.1 Alteration to the Policy

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

**F.2.2** In case of non-disclosure of a condition, we can incorporate additional waiting period of not exceeding 36 months for the said undisclosed disease or condition from the date the un-disclosed

condition was detected and continue with the policy subject to obtaining prior consent from you or Insured Person.

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

**F.2.4 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.

**F.2.5 Change of Policyholder**

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

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

**F.2.6 No Constructive Notice**

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

**F.2.7 Limitation of Liability**

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

**F.2.8 Records to be maintained**

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

**F.2.9 Territorial Jurisdiction**

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

**F.2.10 Policy Disputes**

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

### F.2.11 Loading/Co-payment

We shall apply a risk loading on the premium payable or Co-payment for certain specific conditions as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Schedule of Insurance Certificate. The maximum risk loading applicable shall not exceed 250%. 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).

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 7 days of the issuance of such counter offer. In case, You neither accept the counter offer nor revert to Us within 7 days, We shall cancel Your application and refund the premium paid within the next 7 days.

### F.2.12 Renewal conditions

i. This Policy will automatically terminate at the end of the Policy Period. This Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium. All Renewal application should reach Us on or before the Policy Period End Date.
ii. We may in Our sole discretion, revise the Product and Renewal premium payable under the Policy provided that revision to the Renewal premium are in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.
iii. The premium payable on renewal shall be paid to Us on or before the Policy Period End Date and in any event before the expiry of the Grace Period. For the purpose of this provision, Grace Period means a period of 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.

### F.2.13 Communications & Notices

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

i. To Us, at the address as specified in Schedule of Insurance Certificate
ii. The Policyholder's, at the address as specified in Schedule of Insurance Certificate
iii. No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us
iv. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

### F.2.14 Overriding Effect of Policy Schedule

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

### F.2.15 Policy Termination:

**The policy can also be terminated by Us if:**

a. Any insured person or any person acting on behalf of either has acted in a dishonest and fraudulent manner, under or in relation to this Policy;
b. You or any insured person has not disclosed any true, complete and all correct facts in relation to the Policy; and/or;
c. Continuance of the Policy poses a moral hazard.

**The Policy will be automatically terminated in the following circumstances**:

a. Individual Policy:
   The Policy shall automatically terminate in case of death of the insured person.
b. Family Floater Policy:
   The Policy shall automatically terminate in the case of death of all the insured persons

## G Other Terms and Conditions

### G.1 Claim Procedure

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

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

Insured Person shall call the TPA helpline and furnish Membership Number, Policy Number and the Name of the Patient within 72 hours before admission to hospital for planned hospitalization and not later than 48 hours of admission in case of emergency hospitalization. The insured shall also provide to the TPA by e-mail or through TPA's web portal, the details of hospitalization like diagnosis, name of hospital, duration of stay in hospital, estimated expenses of hospitalization etc. in the prescribed form available with the Insurance help desk at the Hospital. The Insured shall also provide any additional information or medical record as may be required by the medical panel of the TPA. After establishing the admissibility of the claim

under the policy, the TPA shall provide a pre-authorisation to the hospital guaranteeing payment of the hospitalization expenses subject to the sum insured, terms conditions and limitations of the policy. The difference between the amount of pre-authorisation approved and the final hospital bill owing to deductions such as non-payable items, excluded items, policy sub-limits, co-pay amount, deductible amount etc, shall be borne by the insured.

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

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

**Mandatory documents**

1. Discharge summary (detailed) describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.
2. 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. 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.
12. Complete medical records of past hospitalization/treatment, if any.
13. For domiciliary hospitalization claims, a certificate from the attending doctor confirming that the condition of the patient is such that he/she is not in a condition to be removed to a hospital Or there is non availability of bed in the hospital near insured's place of stay.
14. Cancelled cheque leaf in the name of the proposer clearing showing the IFSC code and account holder's name.
15. CKYC number of the proposer. If the insured is not having an existing CKYC number – duly filled CKYC format of the Proposer along with photograph ID and address proof as per AML guidelines of Govt. of India.

**Documents to be submitted if specifically sought:**

1. Copy of indoor case records (including nurse's notes, OT notes and anesthetists' notes, vitals chart). (if available)
2. Copy of extract of Inpatient Register.
3. Attendance records of employer/educational institution.

4. Attending Physician's certificate clarifying
    - reason for hospitalization and duration of hospitalization
    - history of any self-inflicted injury
    - history of alcoholism, smoking
    - history of associated medical conditions, if any

6. Previous master health check-up records/pre-employment medical records, if any.
7. For b) Cataract claims - IOL sticker c) PTCA claims - Stent sticker. d) Implant sticker for surgeries involving implants
8. Any other document necessary in support of the claim on case to case basis.

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

**Annexure-A**

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

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

| | |
|---|---|
| 28 | COURIER CHARGES |
| 29 | CONVEYANCE CHARGES |
| 30 | MEDICAL CERTIFICATE |
| 31 | MEDICAL RECORDS |
| 32 | PHOTOCOPIES CHARGES |
| 33 | MORTUARY CHARGES |
| 34 | WALKING AIDS CHARGES |
| 35 | OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) |
| 36 | SPACER |
| 37 | SPIROMETRE |
| 38 | NEBULIZER KIT |
| 39 | STEAM INHALER |
| 40 | ARMSLING |
| 41 | THERMOMETER |
| 42 | CERVICAL COLLAR |
| 43 | SPLINT |
| 44 | DIABETIC FOOT WEAR |
| 45 | KNEE BRACES (LONG/ SHORT/ HINGED) |
| 46 | KNEE IMMOBILIZER/SHOULDER IMMOBILIZER |
| 47 | LUMBO SACRAL BELT |
| 48 | NIMBUS BED OR WATER OR AIR BED CHARGES |
| 49 | AMBULANCE COLLAR |
| 50 | AMBULANCE EQUIPMENT |
| 51 | ABDOMINAL BINDER |
| 52 | PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES |
| 53 | SUGAR FREE Tablets |
| 54 | CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable) |
| 55 | ECG ELECTRODES |
| 56 | GLOVES |
| 57 | NEBULISATION KIT |

| | |
|---|---|
| 58 | ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC] |
| 59 | KIDNEY TRAY |
| 60 | MASK |
| 61 | OUNCE GLASS |
| 62 | OXYGEN MASK |
| 63 | PELVIC TRACTION BELT |
| 64 | PAN CAN |
| 65 | TROLLY COVER |
| 66 | UROMETER, URINE JUG |
| 67 | AMBULANCE |
| 68 | VASOFIX SAFETY |

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

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

| | |
|---|---|
| 18 | SPUTUM CUP |
| 19 | DISINFECTANT LOTIONS |
| 20 | LUXURY TAX |
| 21 | HVAC |
| 22 | HOUSE KEEPING CHARGES |
| 23 | AIR CONDITIONER CHARGES |
| 24 | IM IV INJECTION CHARGES |
| 25 | CLEAN SHEET |
| 26 | BLANKETS/WARMER BLANKET |
| 27 | ADMISSION KIT |
| 28 | DIABETIC CHART CHARGES |
| 29 | DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES |
| 30 | DISCHARGE PROCEDURE CHARGES |
| 31 | DAILY CHART CHARGES |
| 32 | ENTRANCE PASS / VISITORS PASS CHARGES |
| 33 | EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE |
| 34 | FILE OPENING CHARGES |
| 35 | INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED) |
| 36 | PATIENT IDENTIFICATION BAND / NAME TAG |
| 37 | PULSEOXYMETER CHARGES |

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

| SI No | Item |
|---|---|
| 1 | HAIR REMOVAL CREAM |
| 2 | DISPOSABLES RAZORS CHARGES (for site preparations) |
| 3 | EYE PAD |
| 4 | EYE SHEILD |
| 5 | CAMERA COVER |
| 6 | DVD, CD CHARGES |
| 7 | GAUSE SOFT |
| 8 | GAUZE |
| 9 | WARD AND THEATRE BOOKING CHARGES |
| 10 | ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS |

| | |
|---|---|
| 11 | MICROSCOPE COVER |
| 12 | SURGICAL BLADES, HARMONICSCALPEL,SHAVER |
| 13 | SURGICAL DRILL |
| 14 | EYE KIT |
| 15 | EYE DRAPE |
| 16 | X-RAY FILM |
| 17 | BOYLES APPARATUS CHARGES |
| 18 | COTTON |
| 19 | COTTON BANDAGE |
| 20 | SURGICAL TAPE |
| 21 | APRON |
| 22 | TORNIQUET |
| 23 | ORTHOBUNDLE, GYNAEC BUNDLE |

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

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

| | |
|---|---|
| 16 | SCRUB SOLUTION/STERILLIUM |
| 17 | GLUCOMETER & STRIPS |
| 18 | URINE BAG |

Council for Insurance Ombudsmen

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

**INSURANCE OMBUDSMAN OFFICE LIST**

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

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

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**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 – Premium Illustration**

**Illustration – 1**

| **Age of Member** | **Coverage opted on Individual basis covering each member of the family separately (at single point of time)** | | **Coverage opted on Individual basis covering Multiple members of the family under single policy (Sum Insured is available for each member of policy)** | | | | **Coverage opted on family floater basis with overall Sum Insured (Only one sum insured available for all members of family )** | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| - | **Premium (Rs)** | **Sum Insured (Rs.)** | **Premium (Rs)** | **Discount, if any (Rs.)** | **Premium after discount (Rs.)** | **Sum Insured (Rs.)** | **Premium or consolidated premium for all members of family (Rs.)** | **Floater Discount, if any** | **Premium after discount (Rs.)** | **Sum Insured (Rs.)** |
| 47 | 9,881 | 5,00,000 | 9,881 | N/A | 9,881 | 5,00,000 | 18,154 | N/A | 18,154 | 5,00,000 |
| 43 | 8,154 | 5,00,000 | 8,154 | N/A | 8,154 | 5,00,000 | | | | |
| 20 | 4,112 | 5,00,000 | 4,112 | N/A | 4,112 | 5,00,000 | | | | |
| 15 | 4,112 | 5,00,000 | 4,112 | N/A | 4,112 | 5,00,000 | | | | |
| Total Premium for all members (from Zone 1) of family is Rs. 26,259/- when each member is covered separately.<br><br>Sum Insured available for each individual is Rs. 5,00,000. | | | Total Premium for all members of the family is Rs. 26,259/- when they are covered under a single policy.<br><br>Sum Insured available for each family member is Rs. 5,00,000. | | | | Total Premium when policy is opted on floater basis is Rs. 18,154/-.<br><br>Sum Insured of Rs. 5,00,000 is available for the entire family. | | | |

**Illustration – 2**

| **Age of Member** | **Coverage opted on Individual basis covering each member of the family separately (at single point of time)** | | **Coverage opted on Individual basis covering Multiple members of the family under single policy (Sum Insured is available for each member of policy)** | | | | **Coverage opted on family floater basis with overall Sum Insured (Only one sum insured available for all members of family )** | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| - | **Premium (Rs)** | **Sum Insured (Rs.)** | **Premium (Rs)** | **Discount, if any (Rs.)** | **Premium after discount (Rs.)** | **Sum Insured (Rs.)** | **Premium or consolidated premium for all members of family (Rs.)** | **Floater Discount, if any** | **Premium after discount (Rs.)** | **Sum Insured (Rs.)** |
| 61 | 26,541 | 5,00,000 | 26,541 | N/A | 26,541 | 5,00,000 | 42,159 | N/A | 42,159 | 5,00,000 |
| 57 | 20,741 | 5,00,000 | 20,741 | N/A | 20,741 | 5,00,000 | | | | |
| 24 | 4,112 | 5,00,000 | 4,112 | N/A | 4,112 | 5,00,000 | | | | |
| Total Premium for all members (from Zone 1) of family is Rs. 51,394/- when each member is covered separately.<br><br>Sum Insured available for each individual is Rs. 5,00,000. | | | Total Premium for all members of the family is Rs. 51,394/- when they are covered under a single policy.<br><br>Sum Insured available for each family member is Rs. 5,00,000. | | | | Total Premium when policy is opted on floater basis is Rs. 42,159/-.<br><br>Sum Insured of Rs. 5,00,000 is available for the entire family. | | | |

**Annexure II**

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

| **Policy No** | **Name of Insured** | **Date birth/Age** | **Relationship Proposer** | **City residence** | **Previous Occupation Nature of Work** | **New Occupation or Natu Work** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

Place: _____

Date: _____

(DD/MM/YYYY)

Proposer's Signature_____

Name:_____