



ROYAL SUNDARAM GENERAL INSURANCE CO. LIMITED

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Corona Kavach Policy, Royal Sundaram General Insurance Co. Limited.

Your search for high quality health insurance stops here

We at Royal Sundaram understand that Family is the most important influence in your life and you had always wanted to protect them, and more so in these stressful and tougher covid times where the treatment costs are substantially higher and can leave the family financially impoverished. So, it is always your top priority to avail the much needed insurance cover for the people who matter most in your life besides protecting the family from financial hardship if the unexpected happens in this difficult corona times.

That is why, Royal Sundaram brings to you 'Corona Kavach Policy, Royal Sundaram General Insurance Co. Limited', a standard individual covid health insurance policy for your family. It's a Covid specific Health Insurance Policy, mandated by the Insurance Regulatory and Development Authority of India (IRDAI) to offer a product addressing covid related health insurance requirements of the general public besides bring in uniformity in offering in terms of features and structure of the Covid Health Insurance Product and removing ambiguity in different products by different insurance companies.

Key Features of the Policy

Base Benefits-

- Hospitalisation Expenses and other Expenses for the treatment of Covid on Positive diagnosis of Covid in a government authorized diagnostic centre
- Home Care Treatment Expenses
- Ayush Treatment
- Pre Hospitalization
- Post Hospitalization

Optional Cover

- Hospital Daily Cash (Optional)

Product Benefits – Key Highlights

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy. We cover the following expenses:

1. Base Cover:

1.1. Hospitalization



The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured, for the treatment of Covid on Positive diagnosis of Covid in a government authorized diagnostic centre, including expenses incurred on treatment of any co-morbidity condition. This section shall cover the following:

- a) Room rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home.
- b) Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
- c) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees (including consultation through telemedicine) whether paid directly to the treating doctor /surgeon or to the hospital.
- d) Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, ventilator charges, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, PPE Kit, gloves, mask and such other similar expenses
- e) Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization. This also includes cost of transportation of the insured person from a hospital to another as prescribed by Medical Practitioner.

Note: Expenses on Hospitalization for a minimum period of 24 consecutive hours only are admissible.

1.2. Home Care Treatment Expenses:

The Company shall indemnify the costs of treatment of COVID on positive diagnosis in a Government authorized diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home for a maximum up to 14 days per incident provided that:

- a) The Medical practitioner advises the Insured person to undergo treatment at home.
- b) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
- c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
- d) Insured shall be permitted to avail the services as prescribed by the medical practitioner. Cashless or reimbursement facility are offered under homecare
- e) In case the insured intends to avail the services of non-network provider, claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services.

In this benefit, the following shall be covered if prescribed by the treating medical practitioner and is related to treatment of COVID,

- a. Diagnostic tests undergone at home or at diagnostics centre
- b. Medicines prescribed in writing
- c. Consultation charges of the medical practitioner
- d. Nursing charges related to medical staff
- e. Medical procedures limited to parenteral administration of medicines
- f. Cost of Pulse oximeter, Oxygen cylinder and Nebulizer



Subject to other terms, conditions and exclusions of the policy, expenses payable during the Policy period shall not in aggregate exceed the maximum Sum Insured as specified in the Policy Schedule against this Benefit.

2. AYUSH Treatment

The Medical expenses incurred on hospitalization under AYUSH (as defined in IRDAI (Health Insurance) Regulations, 2016) systems of medicine for the treatment of Covid on Positive diagnosis of Covid in a government authorized diagnostic centre shall be covered up to the Sum Insured without any sub-limits.

3. Pre Hospitalization

The company shall indemnify medical expenses incurred for a period of 15 days prior to the date of hospitalization/home care treatment following an admissible claim under this policy. Pre-hospitalization expenses shall also cover the costs of diagnostics towards Covid.

4. Post Hospitalisation

The company shall indemnify medical expenses incurred for a period of 30 days from the date of discharge from the hospital/completion of home care treatment, following an admissible claim under this policy.

5. No deductibles are permitted in this product
6. The Policy shall include the cost of treatment for any comorbid condition including pre-existing comorbid condition (s) along with the treatment for Covid.

7. Optional cover:

Hospital Daily Cash: The Company will pay 0.5% of sum insured per day for each 24 hours of continuous hospitalization for treatment of Covid following an admissible hospitalization claim under this policy.

The benefit shall be payable maximum up to 15 days during a policy period in respect of every insured person.

Hospital Daily Cash benefit will payable only if it is opted by the customer.

Note: The total amount payable in respect of Base cover and Optional Cover shall not exceed 100% of the sum insured during a policy period.

Policy Features

1. Age Eligibility

Children: The minimum entry age under this policy is between 1 day and 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.



Adult: Minimum entry age shall be 18 years for principal insured and maximum age at entry shall be 65 years for all the insured members including principal insured.

2. Individual & Family Combination

The policy can be purchased on an Individual basis or on a Family Floater basis. In case of a family floater policy, one family will share a single sum insured as opted. Policy can be availed for Self and any one or more of the following family members

- i) Legally wedded spouse.
- ii) Parents and Parents- in-law.
- iii) Dependent Children (i.e. natural or legally adopted) between the age 1 day to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage. A floater cover can cover a maximum of 6 adults and there is no limit on the number of children in a floater policy.

Proposer needs to be mandatorily covered in the Policy. In case the proposer is more than 65 years, he can obtain policy for family, without covering self.

Maximum Family Combination Allowed is 6 Adults + 4 Children. For covering any additional child, separate policy will be required.

3. Policy Period Option

Customer can buy the policy for term of three and half months (3½ months), six and half months (6½ months) and nine and half months (9½ months) including waiting period.

4. Plan & Sum Insured Options

Customer has the option to choose from a wide range of Sum Insured's available:

Sum Insured
Following are the sum insured limits (in Rs.) available under this product:
50000/100000/150000/200000/250000/300000/350000/400000/450000/500000

5. Premium

The Premium charged on the Policy will depend on the Sum Insured, Age, Policy Type (individual or Floater) and the number of persons covered under the floater plan.

For detailed premium chart please refer Annexure "Rate Chart" attached along with this document.

Additionally, the health status of the individual will also be considered consequent to which underwriting loading may be applied.



Premium amount can be made only as a single payment.

6. Discount for Health care workers

A 5% discount will be offered on applicable individual premium rates for Health care workers subject to providing valid ID proof of the same. Health care worker for the purpose of this policy shall mean doctors, nurses, midwives, dental practitioners and other health professionals including laboratory assistants, pharmacists, physiotherapists, technicians and people working in hospitals.

7. Disease Specific Loading/ Co-payment

We shall apply a risk loading on the applicable individual premium rates 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 and overall risk loading applicable shall not exceed 150% per diagnosis / medical condition. These loadings are applied from the inception of the initial Policy including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured). The maximum risk Co-payment shall not exceed 20% per diagnosis/medical condition and an overall risk co-payment of 20%.

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

Following loadings or co-payment may be applied on the policy for the medical conditions listed below if they are accepted at the time of underwriting. The loadings are applicable on individual ailments only.

Table I

Note: Loading will be applicable at an applicable individual premium rates.

Sr. No.	Condition	Medical test	Medical test result	Duration of condition	Loading on base premium	Co-payment for Insured Person
1	Diabetes	HBa1C	Less than or equal to 6	NA	0.0%	Nil
2	Diabetes	HBa1C	More than 8	NA	Decline	Decline
3	Diabetes	HBa1C	More than 6 up to 7	Up to 5 years	100.0%	10%
4	Diabetes	HBa1C	More than 7 up to 7.5	Up to 5 years	150.0%	20%
5	Diabetes	HBa1C	More than 7.5 up to 8	Up to 5 years	Decline	Decline



Sr. No.	Condition	Medical test	Medical test result	Duration of condition	Loading on base premium	Co-payment for Insured Person
6	Diabetes	HBa1C	More than 6 up to 7	More than 5 years up to 10 years	100.0%	20%
7	Diabetes	HBa1C	More than 7 up to 7.5	More than 5 years up to 10 years	150.0%	20%
8	Diabetes	HBa1C	More than 7.5 up to 8	More than 5 years up to 10 years	Decline	Decline
9	Heart Condition	ECG / TMT	Adverse	NA	Decline	Decline
10	Hypertension	Blood Pressure	Above normal up to 140/90	Up to 5 years	20.0%	Nil
11	Hypertension	Blood Pressure	More than 140/90 up to 160/99	More than 5 years up to 10 years	50.0%	10%
12	Hypertension	Blood Pressure	Above normal	More than 10 years	Decline	Decline
13	Any Malignant Cancer	HPE	Confirmatory	NA	Decline	Decline
14	Stroke	Disclosure and MRI	Organic or inorganic	NA	Decline	Decline

Note: The maximum cumulative Underwriting Loading cannot exceed 150%.

There would be conditions whose claims probability cannot be mitigated by exclusions, and such cases may warrant declinature.

8. General Terms and Conditions

A. 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.

B. 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.



C. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representative to inspect such records. The Policyholder or Insured Person

shall furnish such information as the Company may require for settlement of any claim under the policy, within reasonable time limit and within the time limit specified in the Policy.

D. 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

E. Notice & Communication

- i. Any notice, direction, instruction or any other communication related to the policy should be made in writing.
- ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

F. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

G. Multiple Policies

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



H. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if false statement, or declaration is made or used in support thereof, or if fraudulent means or device 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 recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment.

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

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

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

I. Cancellation

- a. The Insured may cancel this Policy by giving 15 days written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.
In case of Policy cancellation by the Insured for a tenure of 3^{1/2} months and 6^{1/2} months Policies, there will be no refund.

Cancellation grid for Policies for a tenure of 9^{1/2} months Policy, following grid will be applicable:

Retention of Premium (basis Policy Period)	
Timing of Cancellation	Rate of Premium to be retained
Up to 90 days	85.00% of policy premium will be retained



Exceeding 90 days	Full policy premium
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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.

- b. The Company may cancel the Policy at any time on grounds of mis-representation, 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 mis-representation, non-disclosure of material facts or fraud.

J. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

In the case of demise of the insured person. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

K. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the policy shall be determined by the Indian court and according to Indian law.

L. Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.



iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

M. Endorsements (Changes in Policy)

- i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
- ii. The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any).

N. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

O. 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. 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.

P. Income Tax benefit

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act 1961. (Tax benefits are subject to change in the tax laws, please consult your tax advisor for more details).

Q. Others (Lifelong renewability, Migration and Portability)

Lifelong renewability, Migration and Portability conditions are not applicable in respect of this product.

R. Renewal of Policy

The renewal under this policy shall be upto the time this product is offered. Until the product is withdrawn, the policy will be renewed except on grounds of misrepresentation /



Non-disclosure of material fact as declared in the proposal form and at the time of claim, fraud committed / moral hazard or non-cooperation of the insured.

The Company may withdraw the product at any time in case it is found unviable to continue. In the event of the Company withdrawing the product the insured will be intimated three months in advance prior to their renewal due date and the insured person shall be offered a suitable alternate product as decided by the Company and the coverage will be subject to the terms and conditions of the alternate product. Credit for the period shall be provided for time bound waiting period in the alternate product for the duration the product was in force.

9. Waiting Periods and 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:

9.1 First Fifteen Days Waiting Period

Expenses related to the treatment of Covid within 15 days from the policy commencement date shall be excluded.

- **Permanent Exclusions:** Investigation & Evaluation, Rest Cure, rehabilitation and respite care, Dietary supplements and substances that can be purchased without prescription unless prescribed by a medical practitioner as part of hospitalization claim or Home care treatment, Unproven Treatments, Any claim in relation to Covid where it has been diagnosed prior to Policy Start Date, Any expenses incurred on Day Care treatment and OPD treatment, Diagnosis /Treatment outside the geographical limits of India, Testing done at a Diagnostic centre which is not authorized by the Government shall not be recognized under this Policy, travels to any country placed under travel restriction by the Government of India.
- For details of permanent exclusions please read the policy terms and conditions or visit www.royalsundaram.in.
- The expenses that are not covered in this policy are placed under List-I of Annexure-A.
- Existing Disease which can be permanently Excluded: In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes. The disease which can be excluded under this section are as under:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9



2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs • C40-C41 Malignant neoplasms of bone and articular cartilage • C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue • D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26



		Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis



9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 - Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease



		resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

10. CLAIM PROCEDURE

Procedure for Cashless claims:

- i. Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.
- ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
- iii. The Company/TPA upon getting cashless request form and related medical information from the insured person/network provider will issue pre-authorization letter to the hospital after verification.
- iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- v. The Company/TPA reserves the right to deny pre-authorization in case the insure person is unable to provide the relevant medical details.



- vi. In case of denial of cashless access, the insure person may obtain the treatment as per treating doctor's advice and submit the claim document to the Company/TPA for reimbursement.

The reimbursement claim shall be processed subject to the admissibility of the claim as per the terms and conditions of the policy.

Procedure for reimbursement of claims:

For reimbursement of claims the insured person any submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

SI	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and Pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment
3	Reimbursement of home care expenses	Within thirty days from completion of home care treatment

Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

- i. Within 24 hours from the date of emergency hospitalization/cashless home care treatment.
- ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

Documents to be submitted:

The claim is to be supported with the following documents and submitted within the prescribed time limit.

Benefits	Claim documents required
Covid Hospitalization Cover	i) Duly filled and signed Claim Form ii) Copy of Insured Person's passport, if available (All pages) iii) Photo Identity proof of the patient (if insured person does not own a passport) iv) Medical practitioner's prescription advising admission



	v) Original bills with itemized break-up vi) Payment receipts vii) Discharge summary including complete medical history of the patient along with other details. viii) Investigation reports including Insured Person's test reports from Authorized diagnostic centre for COVID ix) OT notes or Surgeon's certificate giving details of the operation performed, wherever applicable x) Sticker/Invoice of the Implants, wherever applicable. xi) NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque xii) KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines xiii) Legal heir/succession certificate, wherever applicable xiv) Any other relevant document required by Company/TPA for assessment of the claim.
Home Care Treatment expenses	i) Duly filled and signed Claim Form ii) Copy of Insured Person's passport, if available (All pages) iii) Photo Identity proof of the patient (if insured person does not own a passport) iv) Medical practitioners' prescription advising hospitalization v) A certificate from medical practitioner advising treatment at home or consent from the insured person on availing home care benefit. vi) Discharge Certificate from medical practitioner specifying date of start and completion of home care treatment vii) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

[Note: Insurer may specify the documents required in original and waive off any of above required as per their claim procedure]

The documents should be sent to:

Health Claims Department
M/s. Royal Sundaram General Insurance Co. Limited
Corporate office: Vishranthi Melaram Towers, No. 2 / 319
Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.



Claim documents may also be submitted to local Royal Sundaram Offices address of which can be obtained by calling Customer Service Helpline Number 1860 425 0000.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 30 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 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 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.

Services Offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim admission and assessments, under this policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

- i. Claim settlement and claim rejection;
- ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

Payment of Claim

All claims under the policy shall be payable in Indian currency only.



Disclosure:

All insured persons' personal information collected or held by Royal Sundaram may be used by Royal Sundaram for processing the claims and analysis related to insurance / reinsurance business.

How to Buy Royal Sundaram Policy

Royal Sundaram policy is sold through various channels like telesales team, direct team, individual agents, our website www.royalsundaram.in, licensed brokers and corporate agents.

1. You should go through the product brochure, policy benefits, exclusions etc to thoroughly understand the product before buying.
2. Proposal Form must be filled. You will be required to provide various information (as accurately as possible) such as
 - Insured's name, date of birth, and address.
 - As above for all dependents to be covered by the policy.
 - Selection of sum insured.
 - Any existing health insurance policy details and claims history, if applicable.
 - Disclosure of any Pre-existing Diseases with details.
 - Medical history report for the proposed insured, if necessary.
 - Height and weight for the proposed insured.
 - Signature and date on application, wherever applicable.
 - Premium payment collected and receipted
 - Selection of Third Party Administrator (TPA)
 - Electronic Insurance Account number
3. If You are required to undergo medicals tests as per the chosen Age band and BMI, we would arrange the medical check-up at Our network of diagnostic centres.
4. Based on the above information we will process Your proposal for Insurance and a policy kit containing the Benefit Schedule, Policy Terms and associated documents will be sent to you.

In case we are unable to underwrite Your proposal, We will intimate the same to You and refund any premium that has been collected. Upon assessment if there is any change in terms or premium is loaded then We will inform You about any revised terms through a counter offer letter. We will issue the Policy only once you accept the counter offer. Where You do not agree to the counter offer we will cancel your proposal and refund any premium collected.

Pre-policy Medical Check-up requirements:

We will require You to undergo a medical check-up based on Your age as provided in the grid below or on the basis of Your BMI as per underwriter evaluation. Wherever any pre-existing disease or any other adverse



medical history is declared, We may ask such member to undergo specific tests, as We may deem fit to evaluate such member, irrespective of Age. Medical tests will be facilitated by us and conducted at Our network of diagnostic centres. We will contact You and fix up an appointment for the Medical Examination to be conducted at a time convenient to You. The validity of medical tests would be; for medical tests reports with test result within normal range, the validity is for 6 months from the date of tests done, whereas for medical tests reports with test result not within the normal range, validity is for 3 months from the date of tests done.

Wherever required we may request for additional tests to be conducted based on the declarations on the proposal form and the results of any medical tests that we have received.

Medical Underwriting Grid

#

Medical Underwriting Grid for all Channels

Age	Sum Insured Upto 1.5 Lakhs	Sum insured 2 Lakhs and Above
Up to 18 years	No Check-up [#]	Tele underwriting
19 years to 40 years	No Check-up* [#]	Set 2
41 years and above	Set 2	Set 2

[#] Subject to no adverse medical conditions as disclosed in proposal form.

➤ Medical test:

- **Set 2:** CBC, ESR, URA, MER, HbA1C, Lipid Profile, ECG (2D Echo/TMT can be prescribed based on adverse finding or Co-morbidity), LFT with GGT, RFT, HBsAg, S Creatinine

(Abbreviation of test is provided here: CBC – Complete Blood Count, ESR – Erythrocyte Sedimentation Rate, MER – Medical Examination Report, HbA1C – Glycosylated Hemoglobin Test, S Cholesterol – Serum Cholesterol, ECG – Electrocardiogram, SGPT – Serum Glutamic Pyruvate Transaminase, S Creatinine – Serum Creatinine, TMT – Treadmill Test, LFT with GGT – Liver Function Test, RFT – Renal Function Test, HBsAg – Hepatitis B Surface Antigen, URA – Urine Routine Analysis)

- * If the BMI of proposed insured is more than or equal to 33, proposal will be subject to medical underwriting. Underwriter might trigger the medical test post evaluation of medical condition of the proposed insured.
- Underwriting grid mentioned above is common for all channels. However, we can propose to have a different grid for different channels as per Board approved Underwriting Policy with prior notification to IRDAI.
- Any additional tests such as TMT, 2D Echo USG Abdomen and pelvis, MRI, CT Angio, to be triggered as per underwriter's evaluation.
- No home visits
- Any waiver of Medical tests to be approved by Head– Underwriting and/or Chief Product Officer.



Process for arranging Pre-Policy Medical Check-up (PPMC)

The Pre-Policy Medical Check-up will always be triggered by the Underwriting team. The vendor appointed for the pre policy medical checkup will be notified of the details. The vendor will then call the customer and fix a mutually convenient time for the medical check-up to be conducted. The medical reports in soft copy will be made available to the Underwriting team and hard copies will be couriered directly to the Underwriting department for further processing and risk assessment.

Additionally, in some cases where past Medical Reports are triggered by the Underwriters; past Medical Reports will be collected (soft copies or hard copies) and sent by Contact Center team to Underwriting department.

Cost of Pre-Policy Medical Check-up:

	Proposal Accepted	Proposal Rejected
Corona Kavach Policy, Royal Sundaram General Insurance Co. Limited	Royal Sundaram to reimburse 50% cost of PPMC	Customer to bear 100% cost of PPMC

Note: In case of any cancellation by customer or non-acceptance of counter-offer within specified timeline, we will refund the balance premium excluding the cost of Pre-Policy Medical Checkup (PPMC)

Three potential options will be determined by Royal Sundaram's Underwriter.

- **Low to Medium Risk** - accept application with no condition exclusion(s)
- **Medium to High Risk** – accept application, but special conditions, loading and (or) exclusion(s) as permitted by Regulation shall apply.
- **Very High Risk** – decline policy cover. Royal Sundaram may decline policy cover where potential risk cannot be quantified through the use of best knowledge and expertise. Royal Sundaram will consider past medical history, pathological conditions, acquired disease conditions, deformity or disability, terminal conditions, and/or a combination thereof to determine if a risk is uninsurable.

What to do next: If you wish to know more about Royal Sundaram's 'Corona Kavach Policy, Royal Sundaram General Insurance Co. Limited' Product and/or would like a personal quote, speak to our specially trained sales team or your local agent. They'll take time to fully understand your requirements and help you to select the right plan for you.

Website: www.royalsundaram.in

Disclaimer: This is only a summary of the product features and is for reference purpose only. The details of benefits available shall be as described in the policy document, and will be subject to the policy terms,



conditions and exclusions. Please call our customer service if you require any further information or clarification.

Statutory Warning: Prohibition of rebates (under section 41 of Insurance Act 1938);

No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. If any person fails to comply with sub regulation (1) above, he shall be liable to payment of a fine which may extend to ten lakhs

Annexures:

Annexure A –

- List I – Items for which coverage is not available in the policy,
- List II - Items that are to be subsumed into Room Charges,
- List III - Items that are to be subsumed into Procedure Charges,
- List IV - Items that are to be subsumed into costs of treatment

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

Annexure 1 – Product Benefits Table

Annexure 2 – Rate Tables

Royal Sundaram General Insurance Co. Limited

Corporate Office: Vishranthi Melaram Towers, No. 2/319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097

Registered Office: No. 21, Patullos Road, Chennai - 600002

www.royalsundaram.in

Insurance is the subject matter of solicitation

Unique Identification Number:



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	SPIROMETRE
36	STEAM INHALER
37	ARMSLING
38	THERMOMETER
39	CERVICAL COLLAR
40	SPLINT
41	DIABETIC FOOT WEAR
42	KNEE BRACES (LONG/ SHORT/ HINGED)
43	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
44	LUMBO SACRAL BELT
45	NIMBUS BED OR WATER OR AIR BED CHARGES
46	AMBULANCE COLLAR
47	AMBULANCE EQUIPMENT
48	ABDOMINAL BINDER
49	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
50	SUGAR FREE Tablets
51	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical



	pharmaceuticals payable)
52	ECG ELECTRODES
53	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
54	KIDNEY TRAY
55	OUNCE GLASS
56	PELVIC TRACTION BELT
57	PAN CAN
58	TROLLY COVER
59	UROMETER, URINE JUG

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

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	CRADLE CHARGES
4	COMB
5	EAU-DE-COLOGNE / ROOM FRESHNERS
6	GOWN
7	SLIPPERS
8	TISSUE PAPER
9	TOOTH PASTE
10	TOOTH BRUSH
11	BED PAN
12	FLEXI MASK
13	HAND HOLDER
14	SPUTUM CUP
15	DISINFECTANT LOTIONS



16	LUXURY TAX
17	HVAC
18	HOUSE KEEPING CHARGES
19	AIR CONDITIONER CHARGES
20	IM IV INJECTION CHARGES
21	CLEAN SHEET
22	BLANKETS/WARMER BLANKET
23	ADMISSION KIT
24	DIABETIC CHART CHARGES
25	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
26	DISCHARGE PROCEDURE CHARGES
27	DAILY CHART CHARGES
28	ENTRANCE PASS / VISITORS PASS CHARGES
29	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
30	FILE OPENING CHARGES
31	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
32	PATIENT IDENTIFICATION BAND / NAME TAG
33	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 SHIELD
5	CAMERA COVER
6	DVD, CD CHARGES



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

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

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



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

Annexure X

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

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

Place: _____

Proposer's Signature _____

Date: _____

Name: _____

(DD/MM/YYYY)