

Customer Information Sheet

(Description is illustrative and not exhaustive)

Top Up

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4	Waiting Period	<ul style="list-style-type: none"> Pre-existing Diseases will be covered after a waiting period of 36 months. Specified surgeries/treatments/diseases are covered after specific waiting period of 24 months Specified surgeries/treatments/diseases are covered after specific waiting period of 48 months 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. 	Part IV.A of the policy
5	Payment basis	Payment on indemnity basis (Cashless / Reimbursement) over and above the deductible as applicable	Part II & III of the Policy.
6	Loss sharing	Applicable in way of deductible as selected.	Part I.15 of the Policy
7	Renewal Conditions	The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.	Part V.10 of the policy
8	Renewal Benefits	<ul style="list-style-type: none"> Lifelong Policy Renewal without any exit Age Grace Period - Grace Period of 30 days for renewing the Policy is provided under this Policy Waiting Period - The waiting periods mentioned in the Policy wording will get reduced by 1 year on every continuous renewal of your Policy. Loyalty Perk: Auto increase in Sum Insured by 10% for every claim free year up to maximum of 100% if the Policy is renewed without any break. You can change your Plan/ Optional Cover at renewal of your Policy. 	Part V.10 of the policy Part II.4 Part V.12 of the policy
9	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 in the policy terms and conditions. b. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice.	Part V.15 of the policy
10	Claims	a. For Cashless Service: You may call to our Customer care number for obtaining Cashless facility. You may also visit to our Company website www.libertyinsurance.in to know the list of empaneled Hospitals. b. For Reimbursement of Claim: You need to intimate Us immediately on hospitalization/ injury/ death, further submit all claim documents with supporting details/documents at your own expense to the TPA within 15 days of discharge from the hospital.	Part V.27 of the policy

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11	Policy Servicing/ Grievances/ Complaints	<p>Step 1 Call us on Toll free number: 1800-266-5844 (8:00 AM to 8:00 PM, 7 days of the week) or Email us at: care@libertyinsurance.in or Write to us at: Customer Service Liberty General Insurance Limited 10th Floor, Tower A, Peninsula Business Park, Ganpatrao Kadam Marg, Lower Parel, Mumbai 400 013</p> <p>Step 2 If our response or resolution does not meet your expectations, you can escalate at Manager@libertyinsurance.in</p> <p>Step 3 If you are still not satisfied with the resolution provided, you can further escalate at ServiceHead@libertyinsurance.in</p> <p>IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/</p> <p>Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document.</p>	Part VII. Of the policy
12	Insured's Rights	<p>a. Free Look period of 15 days from the date of receipt of the policy shall be applicable at the inception.</p> <p>b. Lifelong renewability (except on certain specific grounds)</p> <p>c. Right to migrate from one product to another product of the company</p> <p>d. Right to port the from one company to another company</p> <p>Migration & Portability – Call Centre 1800 266 5844 Email address- care@libertyinsurance.in</p> <p>Write to us: Liberty General Insurance Limited 10th Floor, Tower A, Peninsula Business Park, Lower Parel, Mumbai - 400013 E-mail: care@libertyinsurance.in Toll Free No: 1800 266 5844</p> <p>e. Change in SI during the policy term or at the time of renewal –For more details contact Call Centre 1800 266 5844 Email address- care@libertyinsurance.in</p>	Part V.17 Part V.10 Part V.16 & 18 of the policy
13	Insured's Obligations	<p>Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.</p>	
<p>Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.</p>			

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HEALTH CONNECT SUPRA POLICY

PREAMBLE & OPERATIVE CLAUSE

LibertyGeneral Insurance Limited (hereinafter called the "Company", "We, Our, or Us") will provide insurance cover to the person(s) (hereinafter called the "Insured", "You, Your, or Yourself") based on the Proposal made and agreed premium paid within such time, as may be prescribed under the provisions of the Insurance Act, 1938, for the Policy Period stated in the Schedule or during any further period for which the Company may accept payment for the Renewal or extension of this Policy, subject always to the following terms, conditions, provisos, exclusions and limitations contained herein or endorsed or otherwise expressed herein. This Policy records the agreement between the Company (We) and the Insured (You), and sets out the terms of insurance and obligations of each party.

Part I: INTERPRETATIONS & DEFINITIONS

The words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

1. **"Accident"** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **"Age"** means age of the Insured person on last birthday as on date of commencement of the Policy.
3. **"Ambulance"** means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention
4. **"Any one illness"** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital/nursing home where treatment was taken.
5. **"AYUSH Treatment"** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
6. **"An AYUSH Hospital"** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
 - a. Central or State Government AYUSH Hospital or
 - b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
 - c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
7. **"AYUSH Day Care Centre"** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
 - i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
 - ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
8. **"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 or within 30 days thereof
9. **"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
10. **"Condition Precedent"** means a policy term or condition upon which the Insurer's liability under the Policy is conditional upon.
11. **"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.
12. **"Cumulative Bonus/Loyalty Perk"** shall mean any increase in the Sum Insured granted by the Insurer without an associated increase in premium.

HEALTH CONNECT SUPRA POLICY

13. **“Day Care Centre”** means any institution established for day care treatment of illness and/or injuries or a medical set up within a hospital and which has been registered 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 theater of its own where surgical procedures are carried out;
 - iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel
14. **“Day care Procedure/Treatment”** means medical treatment, and/or surgical procedure which is:
 - i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and
 - ii. which would have otherwise required hospitalization of more than twenty four hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.
15. **“Deductible”** is a cost-sharing requirement under this policy that provides that the Company will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will - apply before any benefits are payable by the Company. A deductible does not reduce the Sum Insured
 The deductible shall be applicable towards hospitalization expenses incurred during the policy period by insured (individual policy) or insured family (floater policy) on a per claim basis under “Top Up Plan” and on per Policy year basis under “Super Top Up Plan” as stated under “Schedule of Benefits” of the Policy Document.
16. **“Dependent Child”** refers to a child (naturally or legally adopted), who is financially dependent on the Primary Insured or Proposer and does not have his/her independent sources of income between the age of 91 days and eighteen (18) years, or up to and including the age of twenty-five (25) years if undergoing full time education at an accredited educational institution.
17. **“Dental Treatment”** means treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
18. **“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.
19. **“Domiciliary Hospitalisation”** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
 - a. the condition of the patient is such that he/she is not in a condition to be moved to a hospital or,
 - b. the patient takes treatment at home on account of non-availability of room in a hospital.
20. **“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.
21. **“Endorsement”** means written evidence of change to the Policy including but not limited to increase or decrease in the period, extent and nature of the cover agreed by Us in writing.
22. **“Family”** means the Insured, his/her lawful spouse, dependent child/children, Parents and/or Parents-in-laws.
23. **“Family Floater”** means Policy wherein all Insured Person/s of a family are covered under a single Sum Insured
24. **“Grace period”** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
25. **“Hospital”** means any institution established for in-patient care and day care treatment of illness and/or in injuries/ and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
 - a) has qualified nursing staff under its employment round the clock;
 - b) has at least ten inpatient beds in towns having a population of less than ten lakhs and fifteen in-patient beds in all other places;
 - c) has qualified medical practitioner (s) in charge round the clock;
 - d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
 - e) maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.
26. **“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.

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27. **"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- Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
 - ii. Chronic Condition- A chronic condition is defined as a disease, illness or injury that has one or more of the following characteristics
 - a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
 - b) it needs ongoing or long-term control or relief of symptoms
 - c) it requires rehabilitations for the patient to be specially trained to cope with it
 - d) it continues indefinitely
 - e) it recurs or is likely to recur
28. **"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 registered Medical Practitioner.
29. **"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.
30. **"Insured"** means an individual, a Resident Indian, who has proposed for Insurance and on whose name the Policy is issued.
31. **"Insured Person(s)"** means person(s) named in the Schedule to the Policy.
32. **"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.
33. **"Intensive Care Unit(ICU) 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 intensivist charges.
34. **"Medical Advice"** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
35. **"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.
36. **"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 his license provided that this person is not a member of the Insured Person's family.
37. **"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 the 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
38. **"Migration"** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
39. **"Network Provider"** means hospitals or health care provider enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.
40. **"Non-Network Provider"** means any hospital, day care centre or other provider that is not a part of the Network
41. **"Nominee"** means the person named in the proposal or schedule to whom the benefits under the Policy is nominated by the Insured Person.
42. **"Notification of Claim"** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.
43. **"Out-Patient (OPD) treatment"** means the one 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.
44. **"Policy"** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

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45. **“Policy period”** means the period between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.
46. **“Policy Schedule”** means the Policy Schedule attached to and forming part of Policy.
47. **“Policy year”** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.
48. **“Portability”** means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
49. **“Pre-existing Condition”** Preexisting disease means any condition, ailment, injury or disease
 - a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
 - b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
50. **“Proposal and Declaration Form”** means any initial or subsequent declaration made by the Insured/ Insured Person(s) and is deemed to be attached and forming part of this Policy.
51. **“Pre-hospitalization Medical Expenses”** means medical expenses incurred during the period of 30 days preceding the hospitalisation of the Insured Person, provided that:
 - i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
52. **“Post-hospitalization Medical Expenses”** means medical expenses incurred during the period of 60 days immediately after the insured person is discharged from the hospital provided that:
 - i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
 - ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.
53. **“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.
54. **“Reasonable and Customary charges”** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved
55. **“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.
56. **“Room rent”** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
57. **“Service Provider”** means a Health care provider appointed by Insurer to provide services as enlisted under Part III.4 of the Policy
58. **“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.
59. **“Sum Insured”** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.
60. **“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.
61. **“Unproven/Experimental treatment”** means treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.
62. **“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 renewed without any break.
63. **“We/Our/Us”** means the Liberty General Insurance Limited
64. **“You/Your”** means the Insured named in the Schedule who has concluded this Policy with Us

HEALTH CONNECT SUPRA POLICY

Part II: SCOPE OF COVER

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse actual expenses incurred in excess of the Deductible as specified in the Policy Schedule.

The company will pay for the Medical Expenses, in excess of deductible stated in the Policy Schedule either on per claim basis or when the aggregate of covered medicalexpenditures exceeds the deductible applicable on policy per year basis depending upon the plan opted.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured and Reload Sum Insured if any available to the Insured and stated in the Policy Schedule.

1. In-Patient Hospitalization Expenses

The Company undertakes to indemnify Insured person against any disease or Any One Illness or any injury during the Policy Period and if such disease or injury shall require any such Insured Person, upon the advice of a duly qualified physician/ Medical Practitioner to incur in-patient care expenses for medical/surgical treatment at any Hospital in India, towards following expenses, subject to the terms, conditions, exclusions and definitions contained herein or endorsed.

- i. Room, Boarding expenses
- ii. Intensive Care Unit bed charges
- iii. Doctor's fees
- iv. Nursing Expenses
- v. Surgical Fees, Operation Theatre Charges, Anesthetist, Anesthesia, Blood, Oxygen and their administration, Physical Therapy
- vi. Prescribed Drugs and medicines consumed on the premises
- vii. Investigation Services such as Laboratory, X-Ray, Diagnostic tests
- viii. Dressing, Ordinary splints and plaster casts
- ix. Cost of Prosthetic and other devices- that are used intra operatively during a Surgical Procedure, if recommended by the attending Medical Practitioner

2. Pre-Hospitalisation Expenses

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy immediately before the Insured Person was hospitalised, provided that:

- i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
- ii. There is a valid claim admissible under Part II 1 (In-patient Hospitalization Expenses) of the Policy.

3. Post-Hospitalisation Expenses

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy, immediately after the Insured Person was discharged following Hospitalisation, provided that:

- i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and
- ii. There is a valid claim admissible under Part II 1 (In-patient Hospitalization Expenses) of the Policy.

4. Day Care Procedure/Treatment

The Company will indemnify medical expenses incurred on a treatment towards a Day Care procedure mentioned in the list of Day Care Procedures in the Policy and as available on the Company's web-site, where the procedure or surgery is taken by the Insured Person as an inpatient in less than 24 hours in a Hospital or standalone day care center but not in the Outpatient department of a Hospital.

5. Cumulative Bonus/Loyalty Perk

The Policy provides for auto increase in Sum Insured by 10% on the Sum Insured for every claim free Policy year up to a maximum of 100% of the Sum Insured if the policy is renewed with us without any break or within the Grace period as defined under the Policy.

- a. For a Family Floater policy, the loyalty perk shall be available only on floater basis and shall accrue only if no claim has been made in respect of any Insured Person during the expiring Policy Year. The loyalty perk which is accrued during the claim free Policy Year will only be available to those Insured Persons who were insured in such claim free Policy Year and continue to be insured in the subsequent Policy Year.
- b. If the Insured Person/s in the expiring Policy are covered on a Floater Basis and the Policy renewal for such Insured Person/s is done by splitting the floater Sum Insured into 2 or more floater / individual covers, then the Loyalty Perk of the expiring Policy shall be apportioned to such renewed Policy/ies in proportion to the Sum Insured under each of the renewed Policy/ies.
- c. If the Insured Person/s in the expiring Policy are covered on an Individual basis and thereby enjoy separate Loyalty Perk in the expiring Policy/ies, and such expiring Policy/ies is renewed with the Company on a Floater Basis, then the Loyalty Perk carried forward under such renewed floater Policy would be the least of the Loyalty Perk/s earned under the expiring Policy/ies..
- d. Entire loyalty perk 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.
- e. In case of a claim in the Policy, the renewal of such Policy would not qualify for any fresh Loyalty Perk as well as the existing and/or unutilized Loyalty Perk if any will get reduced by 10% at the time of renewal, in the renewed policy.

6. PreventiveCare

The Company will provide below additional benefits which would help in preventing and/or bettering current Health condition/s.

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The below services will be provided by Us/Our appointed service provider and can be availed anytime during the policy period and there are no restrictions on the number of times the facility can be utilized.

A. First Medical Opinion:

A First medical opinion service from our expert panel is available for all Insured Person/s seeking information that will give them confidence in their medical diagnosis and treatment plan. At the request of the Insured Person/s, the company shall arrange for a First Opinion which is subject to the following:

- A First Medical Opinion service provides an unbiased opinion on simple medical queries that have not been taken to a medical expert as of yet.
- This benefit can be availed only once during the policy Period by the Insured Person
- The Insured Person is free to choose whether or not to obtain the First Opinion, and if obtained, whether or not to act on the same.
- The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any First Opinion or for any consequences of actions taken or not taken in reliance thereon
- Any First Opinion provided under the Benefit shall not be valid for any medico-legal purposes.

B. Live Health Talk:

A unique offering where the Insured Person(s) can log in through their unique login ID on the Portal and schedule a live chat with a practicing doctor to discuss health problem.

C. Electronic Medical Record Management (EMRM):

Our Portal provides storage for all your medical documents and reports centrally in one location. With EMRM you may retrieve your medical documents at your convenience through the internet. This facility provides you easy accessibility of the documents anytime and anywhere in a secured way.

D. Fortnightly Newsletters:

Relevant and Crisp Fortnightly Publication for Wellness Awareness would be available for you on the Portal.

Part III: OPTIONAL COVER(S)

The optional cover(s) shall be available only if the same is specifically mentioned in the Policy Schedule and available on payment of premium as applicable. The Insured has an option to select the cover/s either on individual /combination basis, along with the covers specified under Part II. Scope of Covers of the Policy.

The company will pay for the Medical Expenses, in excess of deductible stated in the Policy Schedule either on per claim basis or when the aggregate of covered medical expenses exceeds the deductible applicable on policy per year basis depending upon the plan opted.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured and Reload Sum Insured if any available to the Insured and stated in the Policy Schedule.

1. Reload of Sum Insured

When the Sum Insured is exhausted due to claims made and paid during the Policy Year or made during the Policy Year and accepted as payable under Part II 1 (In-patient Hospitalization Expenses) of the Policy; the Company agrees to automatically Reload the Sum Insured equivalent to the original Sum Insured specified in the Policy Schedule, for the particular policy year, provided that:

- The Reload Sum Insured will be triggered immediately after the original Sum Insured and Cumulative Bonus (if any) has been completely exhausted during that Policy Year;
- The Reload Sum Insured is available for the medical expenses incurred only in India
- The Reload Sum Insured can be used only for such claims as is admissible in terms of Part II 1 (In-patient Hospitalization Expenses) of the Policy and available for the Medical expenses incurred during In-patient hospitalization period only.
- The Reload Sum Insured will be available during the Policy Year till it is exhausted completely.
- Any unutilized Reload amount cannot be carried forward to any subsequent Policy Year/renewal of the Policy.
- In case of Portability, the credit for Sum Insured would be given only to the extent of the original Sum Insured.
- The deductible provision would apply to the Reload Sum Insured in the same manner as was applicable to the original Sum Insured i.e., on a per claim basis in case of "Top Up" and on per year basis in case of "Super Top Up" as stated under "Schedule of Benefits" of the Policy Document.

If the policy is a Family Floater, then the Reload Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Sum Insured was exhausted.

2. AYUSH Treatment

The Company will indemnify up to the amount specified in the Policy Schedule, for the Medical Expenses incurred in excess of deductible stated in the Policy Schedule either on per claim basis or when the aggregate of covered medical expenses exceeds the deductible applicable on policy per year basis depending upon the plan opted, for the treatment taken under Ayurveda, Unani, Sidha and Homeopathy in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health provided that the hospitalization is not for evaluation and/or investigation purpose only and treatment is availed in India only.

3. World-wide Coverage

The Company will indemnify up to the amount specified in the Policy Schedule, as per the Sum Insured and plan chosen in excess of the Deductible as specified in the Policy Schedule, for the emergency care Medical Expenses incurred outside India, in respect of the Insured Person incurred during the Policy Year, provided that:

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- i. The Insured person(s) is/are outside India for the purpose other than undergoing medical treatment/procedure
- ii. The medical symptoms first originated whilst the Insured Person(s) is/are outside India
- iii. The treatment is Medically Necessary and has been certified by a Medical Practitioner as an Emergency care which cannot be deferred till the date of Insured Person/s return/s to India.
- iv. The intimation of such hospitalization to the Company or our Service Provider is within 24 hours of admission
- v. The Emergency Care Medical Expenses incurred during In-patient Hospitalization only shall be covered.
- vi. Pre-existing diseases shall be excluded.
- vii. Any payments under this benefit will only be made in India, in Indian Rupees and on reimbursement basis. The payment of any claim will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for payment of the claim under this benefit.
- viii. Waiting Periods of 30 days and Two Years as stated under Section D. Exclusions of the Policy shall be waived off under this cover.
- ix. We shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.
- x. The cover is available for a maximum period of 180 consecutive days.

4. Wellness & Assistance Program-

The below services will be available when the Insured/Insured member(s) is/are more than 150 kilometers away, within Indian territory, from their residential address as provided in the Proposal Form. The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company and can be availed anytime during the policy period and there are no restrictions on the number of times the facility can be utilized.

- i. Medical Consultation, Evaluation and Referral- In case of any emergency situation, We/our Service Provider will evaluate, troubleshoot and make immediate recommendations including referrals to qualified doctors and/or hospitals. The company will only arrange for the medical consultant, the consultant fee will be borne by the policyholder.
- ii. Medical Monitoring and Case Management- A team of doctors, nurses, and other medically trained personnel would be in regular communication with the attending physician and hospital, monitors appropriate levels of care and relay necessary and legally permissible information to the members of the Family / employer.
- iii. Emergency Medical Evacuation- If the Insured / Insured member/s becomes ill or injured in an area where appropriate care is not available, the Company /via Service Provider at its expense will intervene and use available transportation equipment and personnel necessary to evacuate the Individual safely to the nearest facility for medical care. Such emergency medical evacuation would be done either by ground or air solely at the discretion of the Company.
- iv. Compassionate Visit: When an Insured Person/s is/are hospitalized for more than seven (7) consecutive days, The Company/ Service Provider will arrange for a family member or a personal friend to travel to visit the Insured Person/s, by providing an appropriate means of transportation

Part IV: EXCLUSIONS

A. Waiting Period:

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

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 as per the Plan mentioned in the Policy schedule i.e. until the expiry 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. If 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 be extent of prior coverage.
- d. Coverage under the policy after the expiry of applicable months as per the Plan, for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by the Insurer.

2. Specified disease/procedure waiting period - Code- Excl02

- a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of below mentioned months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on Portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

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f. List of specific diseases/procedures

Sr. No.	Two Year (24 months) Waiting Period	Four Year (48 months) Waiting Period
1	Cataract	*Treatment related to Neurotic, stress-related and somatoform disorders (F45 and F48)
2	Benign Prostatic Hypertrophy	Treatment of Bipolar (F31), Delirium (F05), Dementia (F00-F03), Depression (F30, F32, F33), Hyperkinetic (F90), Mental retardation (F70-79), Schizophrenia (F20-29)
3	Hernia	Surgical treatment of Obesity
4	Hydrocele	
5	Fistula in anus	
6	Piles	
7	Sinusitis and related disorders	
8	Fissure	
9	Gastric and Duodenal ulcers	
10	Gout and Rheumatism	
11	Internal tumors, cysts, nodules, polyps, breast lumps (unless malignant)	
12	Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus	
13	Polycystic ovarian diseases	
14	Skin tumors (unless malignant)	
15	Benign ear, nose and throat (ENT) disorders and surgeries, adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty	
16	Dilatation and Curettage (D&C);	
17	Congenital Internal Diseases	
18	Calculus diseases of Gallbladder and Urogenital system	
19	Hypertension and Diabetes and related complications	
20	Joint Replacement due to Degenerative condition	
21	Surgery for prolapsed inter vertebral disc unless arising from accident	
22	Age related Osteoarthritis and Osteoporosis	
22	Spondylosis / Spondylitis	
23	Surgery of varicose veins and varicose ulcers.	
24	Diabetes & related complications: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hypo/Hyperglycemic Shocks	
25	Hypertension & related complications: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal bleed/Haemorrhages.	
26	Treatment for correction of eye sight (laser surgery) due to refractive error	
27	*Treatment related to Anxiety (F06, F40-41), Conduct & Mood disorders (F34, F38-39, F92-93, F98), Personality disorders (F60-61, F93) and stress (F43) F04, F07, F09 (Organic, including symptomatic, mental disorders)	

*The illnesses/diseases mentioned with the coding in the bracket such as F06, F40 are as per the 'International Classification of Diseases (ICD's). ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion.

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3. 30-day Waiting Period - Code-Excl03

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

B. EXCLUSIONS

We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary elsewhere in this Policy:

4. Investigation & Evaluation – Code-Excl04

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

5. Rest Cure, rehabilitation and respite care-Code- Excl05

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

6. Obesity/ Weight Control:Code- Excl06

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

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

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

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

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

9. Hazardous or Adventure sports: Code- Excl09

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

10. Breach of law:Code- Excl 10

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

11. Excluded Providers : Code-Excl11

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

12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl 12

13. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code - Excl 13

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-Excl 14

15. Refractive error: Code – Excl15

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

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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.
17. **Birth control, Sterility and Infertility: Code- Excl17**
 Expenses related to Birth Control, 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
18. **Maternity: Code Excl18**
 - i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period
19. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice & Trichomoniasis, Human T Cell Lymphotropic Virus Type III (HTLV-III or IITLB-III) or Lymphadenopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
20. Any dental treatment or surgery unless requiring hospitalization arising out of an accident.
21. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
22. Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, routine eye and ear examinations, dentures, artificial teeth and all other similar external appliances and /or devices whether for diagnosis or treatment.
23. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.P.A.D) and oxygen concentrator or asthmatic condition, cost of cochlear implants.
24. External Congenital Anomaly.
25. Circumcision unless necessary for treatment of an illness or as may be necessitated due to an Accident
26. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy.
27. Treatment received outside India under Optional cover 'World-wide cover'
28. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, mutiny, military or usurped acts, seizure, capture, arrest, restraints and detainment of all kinds.
29. Act of self-destruction or self-inflicted, attempted suicide or suicide while sane or insane or illness or injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens.
30. Any charges incurred to procure any medical certificate, treatment or illness related documents pertaining to any period of Hospitalization or illness.
31. Personal comfort and convenience items or services, TV (wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs, (except patient's diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service
32. Expenses related to any kind of RMO charges, service charge, surcharge, admission fees, registration fees, night charges levied by the hospital under whatever head.
33. 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.

HEALTH CONNECT SUPRA POLICY

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

In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded.

34. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products

35. Drugs or treatment and medical supplies not supported by a prescription from a Medical Practitioner.

Part V: GENERAL TERMS AND CONDITIONS

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 by the policyholder. ("Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sum insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract

3. Observance of Terms and Conditions

The due observance and fulfillment of the terms, conditions and Endorsements, including the payment of premium of this Policy and compliance with specified claims procedure insofar as they relate to anything to be done or complied with by the Insured shall be a Condition Precedent to any liability of the Company to make any payment under this Policy.

4. Alterations to the Policy

This Policy together with the Policy Schedule constitutes the complete contract of insurance. This Policy cannot be changed or varied by any one (including an insurance agent or broker) except the Company, and any change We make will be evidenced by a written Endorsement signed and stamped by the Company.

5. Material Change

Material information to be disclosed includes every matter that the Insured/s are aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to the Company in order to accept the risk of insurance and if so on what terms. The Insured/s must exercise the same duty to disclose those matters to the Company before the Renewal, extension, variation, endorsement or reinstatement of the contract.

6. Records to be maintained

The Insured Person(s) shall keep an accurate record containing all relevant medical documents including a variety of types of "notes" entered over time by Medical Practitioner, recording observations and administration of drugs and therapies, Investigation reports and shall allow the Company to inspect such record. The Insured Person/s shall furnish such information to the Company as may be required under this Policy, during the Policy Period or until the final adjustment, if any, and resolution of Claim/s under this Policy whichever is later.

7. Notice of charge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured Person/s, his/her/their Nominees or legal representatives, as the case may be, of any Medical expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

8. Multiple Policies

- i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of his/her policies. In all such cases, the Insurer chosen by the Insured person 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.
- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy/ for the amounts disallowed under the other policy/policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the insured person shall have the right to choose the insurer from whom he/she wants to claim the balance amount.
- iv. Where an insured person(s) has/have policies from more than one insurer to cover the same risk on indemnity basis, the insured person(s) shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

HEALTH CONNECT SUPRA POLICY

9. 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 any 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 and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later 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 to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- the active concealment of a fact by the insured person having knowledge or belief of the fact;
- any other act fitted to deceive; and
- 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

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period. No loading shall apply on renewals based on individual claims experience

Any revision or modification in a Policy which is approved by the Authority shall be notified to each policy holder at least three months prior to the date when such revision or modification comes into effect.

Insured Person(s) could avail of policy renewal in terms of the applicable Portability norms governing such renewals and the same would be renewed in accordance with the Company's Board approved underwriting policy.

The table below illustrates the waiting period which would be applicable as per Portability norms:

SI No	No of years of continuous insurance cover with previous insurer(s)	Waiting period to be served with new insurer in number of days/years upon Portability		
		30 days waiting period	2 years waiting period	4 years waiting period for PED
1	1 Year	NIL	1 Year	3 Years
2	2 Years	NIL	NIL	2 Years
3	2 Years	NIL	NIL	1 Year
4	2 Years	NIL	NIL	NIL

11. Entry Age

Minimum entry Age: Adult – 18 years and 91 days for children; Maximum entry Age: 65 Years

Child/children below 25 years of age can be covered provided either of the parent is insured under the policy.

12. Increase in Sum Insured or Reduction in Deductible or Change in Plan

Sum Insured can be enhanced or deductible amount can be reduced or Policy Plan can be changed only at the time of renewal subject to no claim having been lodged/ paid under the earlier policy/ies and with the specific approval and acceptance subject to medical clearance called for analysing sub-standard risk, by the Company. In all such case of increase in the Sum Insured, waiting period will apply afresh in relation to the amount by which the Sum Insured has been enhanced

13. Sub-standard Risk

Proposals where the Health status is adverse, as revealed in the proposal form and/or followed by health check-up may be accepted at the sole discretion of the Company with an increased risk rating which shall not exceed 100% of normal slab premium per diagnosis / medical condition and not over 200% of normal slab premium per person. Applicable for all subsequent renewal(s) involving age slab changes and increase in Sum Insured. In all such cases, we would send a communication letter to the Proposer and obtain his/her consent before acceptance of the Proposal.

If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing, then Pre-Existing Condition Exclusion (Part IV.A.1.) shall be applicable.

HEALTH CONNECT SUPRA POLICY

14. Pre-Policy Health Check Up:

The Company may require Individuals with adverse Health status as declared on the Proposal Form, to undergo appropriate Pre-Policy health check-up at our network list of diagnostic centers as available on our website. The result of these tests will be valid for a period of 3 months from the date of tests performed.

The Company reserves its right to require any individual to undergo such medical tests or any further additional tests, at the sole discretion of the Company to determine the acceptance of a Proposal.

If the proposal is accepted we shall refund 50% of the health check-up cost (on our pre agreed rates with the network provider).

15. Cancellation/Termination

This Policy will terminate at the expiration of the period for which premium has been paid or on the Expiration Date shown in Policy Schedule.

The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Cancellation period	1 Year Policy	2 Year Policy	3 Year Policy
Up to 1 Month	75%	87.50%	92.00%
Up to 3 Months	50%	75.00%	83.00%
Up to 6 Months	25%	62.50%	75.00%
Up to 9 Months	NIL	50.00%	67.00%
Up to 12 Months	NIL	42.00%	55.00%
Up to 15 Months	NIL	25.00%	50.00%
Up to 18 Months	NIL	12.50%	42.00%
Up to 24 Months	NIL	NIL	30.00%
Up to 30 Months	NIL	NIL	8.00%
Up to 36 Months	NIL	NIL	NIL

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 misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

In the event of the death of the Insured Person/s during the currency of the Policy, due to any reason and subject to there being no claim reported under the Policy, the Policy would cease to operate and the Nominee/legal heir would be entitled to a refund in premium from the date of death to the expiry of Policy and such refund would be governed by the provisions relating to the Cancellation by Insured/ Insured Person/s as specified above. In case of a Family cover, upon the death of the Policy holder, this Policy shall continue till the end of the Policy Period. If the other Insured Person/s wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of an Insured.

16. Withdrawal of Product

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.

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.

17. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

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

HEALTH CONNECT SUPRA POLICY

18. Continuity Benefits

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 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 policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefit in waiting periods as per IRDA guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link <https://www.libertyinsurance.in/>

Dependent child/children: covered with Us shall have the option to continue renewal by migrating to a suitable policy at the end of the specified age. Due credit for continuity in respect of the previous policy period will be allowed provided the earlier policies have been maintained without a break.

Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for Migration of the policy atleast 30 days before the policy renewal date as per the IRDA Guidelines on Migration. If such person is presently covered and has been continuously covered without any lapse under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDA Guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer the link <https://www.libertyinsurance.in/>

19. Disclaimer

It is being expressly agreed and declared that if the Company shall disclaim liability for any claim hereunder and such claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in a court of law then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

20. Area of Validity

The Policy shall provide for eligible medical treatment taken within India & all the benefits under the Policy shall be payable in Indian rupees only. This Clause is not applicable for the Optional cover 'World-wide coverage' if opted by the Insured/s and specified so in the Schedule to this Policy.

21. Policy Disputes

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to, by both the Insured and the Company to be subject to Indian law. Each party agrees to be subject to the executive jurisdiction of the High Court of Mumbai and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

22. Arbitration

If any dispute or difference shall arise as to the quantum to be paid under this 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 thereto or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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 the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

It is hereby expressly stipulated and declared that it shall be a Condition Precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

23. Notice

Every notice and communication to the Company required by this Policy shall be in writing, within specified time and be addressed to the nearest office of the Company. In case the Policy is sold via voice log the notice to the Company may be placed via same mode.

24. Electronic Transaction

The Insured agrees to adhere to and comply with all such terms and conditions involving transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of this Policy or its terms.

25. 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.

HEALTH CONNECT SUPRA POLICY

26. 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 be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

27. Claim Settlement (Provision for Penal Interest)

- 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.
- 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.
- 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.
- 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.

Explanation: "bank rate" shall mean the rate fixed by Reserve Bank of India (RBI) at the beginning of the financial year in which the claim falls due.

28. 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.

29. 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.

30. Notices:

Any notice, direction or instruction given under this policy shall be in writing and delivered by hand, post, or fax to:

In case of Insured - As mentioned in the schedule

In case of the Company:

Liberty General Insurance Ltd.

10th Floor, Tower A, Peninsula Business Park,

Ganpatrao Kadam Marg,

Lower Parel, Mumbai – 400013

Tel: 02207001313

Fax : 022 67001606

Notice and instruction will be deemed served 7 days after posting or immediately upon recipient in the case of hand delivery, fax or e-mail.

31. Customer Service:

If at any time the Insured requires any clarification or assistance, the insured may contact the offices of the Company at the address specified during normal business hours.

32. Claim Procedure:

a) Notification of Claim:

Upon the happening of any event giving rise or likely to give rise to a claim under this Policy, the Insured Person/s shall give immediate notice to the TPA named in the Policy/Health Card or the Company by calling toll-free number as specified in the Policy/Health Card or in writing to the address shown in the Schedule with Particulars below:

- Policy Number / Health Card No
- Name of the Insured / Insured Person availing treatment
- Details of the disease/illness/injury
- Name and address of the Hospital
- Any other relevant information

Intimation must be given at least 48 hours prior to planned hospitalization and within 24 hours of hospitalization in case of emergency hospitalization.

All claim related documents need to be submitted within 7 days from the date of completion of treatment -as mentioned in the policy schedule.

The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured Person/s. The Insured Person/s shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder. The Company shall settle claims, including its rejection, within 30 working days of receipt of the last required documents.

The notification of claim is mandatory, even for claims falling within the deductible.

In case of covered Hospitalization, the costs of which were not initially estimated to exceed the Deductible but were subsequently found likely to exceed the Deductible, the intimation should be submitted along with details of intimation made to the other insurer/ reimbursement provider immediately on knowing that the Deductible is likely to be exceeded.

HEALTH CONNECT SUPRA POLICY

b) Claim Procedure

- 1) Cashless Facility:(applicable where the Insured Person/s has opted for cashless facility in a Network Hospital) - The Insured Person must call the helpline and furnish membership number and Policy Number and take an eligibility number to confirm communication. The same has to be quoted in the claim form.

The call must be made 48 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 24 hours of admission.

- i. The company may provide Cashless facility for Hospitalisation expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorisation letter to the health care service provider.
- ii. For the purpose of considering Pre-Authorisation and Cashless facility, the Insured Person/s shall submit to the TPA complete information of the disease, requiring treatment along with necessary certification from the Hospital/Medical Practitioner
- iii. If the claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorisation to the Hospital concerned for cashless facility whereby hospitalization expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorisation.
- iv. Cashless facility will not be available in Non-network Hospital and may be declined even for treatment at a network hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such cases, the Insured Person/s shall bear such expenses and claim reimbursement immediately after discharge from the Hospital.
- v. The list of Network hospitals where we are having cash less arrangement would be made available to the Policy holder and subsequent amendments to the same would also be duly communicated by us/ the TPA service provider.
- vi. In case where initial covered Medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to other Insurer(if covered under any other Health Insurance Policy).

- 2) Reimbursement: Notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/ injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us immediately on hospitalization/ injury/ death, failing which admission of claim would be based on the merits of the case at our discretion. The Insured Person/s shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 15 days of discharge from the hospital the following:

- i. Claim form duly completed in all respects
- ii. Original Bills, Receipt and Discharge certificate / card from the Hospital.
- iii. Original Cash Memos from Hospital(s)/Chemist(s), supported by proper prescriptions.
- iv. Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.
- v. Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt.
- vi. Attending Doctor's / Consultant's / Specialist's / - Anesthetist's original bill and receipt, and certificate regarding diagnosis.
- vii. Medical Case History / Summary.
- viii. Original bills & receipts for claiming Ambulance Charges

The Insured Person/s shall at any time as may be required authorize and permit the TPA and/or Company to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim. The Company may call for additional documents/ information and/or carry out verification on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company.

The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured/ Insured Person/s. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

c) Payment of Claim:

- i. We shall be under no obligation to make any payment under this Policy unless We have received all the premium payments in full and all payments have been realized and We have been provided with the documentation and information. We have requested to establish the circumstances of the claim, its quantum or Our liability for it
- ii. We will only make payment to You under this Policy. In the event of Your death, We will make payment to the Nominee (as named in the Policy Schedule)/ legal heir as the case may be. No assignment of this Policy or the benefits there under shall be permitted.
- iii. Payments under this Policy shall only be made in Indian Rupees.
- iv. Our liability to make payment under this policy will only begin when the Deductible as mentioned in Schedule is exceeded.
- v. All admissible claims shall be assessed basis following order:

I. Top Up

- a) Basis of claim payment shall be Medical expenses incurred for each event/hospitalization incepting during each policy year payable under this Policy and which exceed the Deductible applicable per event/hospitalization basis mentioned in the Policy Schedule.
- b) Each event (hospitalization), if more than one, during the Policy period shall be separately assessed subject to the specified Deductible mentioned in the Policy Schedule except in case of relapse within 45 (Forty Five) days, as defined under Any One Illness, this will be applicable for Individual Policy as well as for Family Floater Policy
- c) We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

HEALTH CONNECT SUPRA POLICY

ii. Super Top Up

- a) Basis of claim payment shall be aggregate of Medical expenses incurred for all hospitalization (s) incepting during each policy year payable under this Policy and which exceeds the Deductible applicable per policy year basis as mentioned in the Policy Schedule
- b) Any claim under this Policy shall be payable by Us only if the sum of the amount of covered Medical Expenses in respect to Hospitalisation(s) of Insured Person (on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy) exceeds the Deductible applicable on per year basis and all limits of reimbursement under other Health Insurance policy (if available) to the insured person/s have been exhausted.
- c) We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person had taken reasonable care, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

d) CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

In-patient Treatment/ Day Care Procedures

- ☐ Duly filled and signed Claim Form
- ☐ Photocopy of ID card / Photocopy of current year policy
- ☐ Original Detailed Discharge Summary / Day care summary from the hospital. Original consolidated hospital bill with bill no. and break up of each Item, duly signed by the Insured
- ☐ Original payment Receipt of the hospital bill with receipt number
- ☐ First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from attending Medical Practitioner / Surgeon demanding such test
- ☐ Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts
- ☐ Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same
- ☐ Original medicine bills and receipts with corresponding Prescriptions.
- ☐ Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.
- ☐ Hospital Registration Number and PAN details from the Hospital
- ☐ Doctors registration Number and Qualification from the doctor

Road Traffic Accident

In addition to the In-patient Treatment documents:

- ☐ Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

In Non Medico legal cases

- ☐ Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

In Accidental Death cases

- ☐ Copy of Post Mortem Report (if conducted) & Death Certificate

For Death Cases

In addition to the In-patient Treatment documents:

- ☐ Original Death Summary from the hospital.
- ☐ Copy of the Death certificate from treating doctor or the hospital authority.
- ☐ Copy of the Legal heir certificate (where nomination is not available)

Pre and Post-hospitalisation expenses

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Medicine bills, original payment receipt with prescriptions.
- ☐ Original Investigations bills, original payment receipt with prescriptions and report.
- ☐ Original Consultation bills, original payment receipt with prescription.
- ☐ Copy of the Discharge Summary of the main claim.

Tele-medicine

- ☐ A proper invoice or numbered bill of consultation with date
- ☐ A proof of payment either a Online, G-PAY or Pay-TM
- ☐ The consultation note or Prescription with Physicians registration number and details
- ☐ All investigation report advised with bills and prescription

We may call for additional documents/ information as relevant to the claim.

Applicable to all claims under the Policy:

- In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, We shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.
- If required, the Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense.
- If required, the Insured person must agree to be examined by a medical practitioner of our choice at Our expenses
- The Policy excludes the Standard List of excluded items as attached in this Policy document.

HEALTH CONNECT SUPRA POLICY

- We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions or reject the claim as per the Policy terms and conditions within 30 days of submission of all necessary documents / information and any other additional information required for the settlement of the claim. However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, 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, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document
- All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed under IRDAI (Protection of Policyholders Regulation), 2017, we shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us For the purpose of this clause, 'bank rate' means "Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due"
- No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy

Part VI: DISCOUNT PARAMETERS

The following discounts on the premium payable based on the declarations made in proposal form, health status of the insured and coverage sought:

- Family Discount: A Family discount of 10% will be given if 2 or more family members are covered on Individual Sum Insured basis and is available to each member under the policy
- Multi-year Policy Discount: A discount of 7.5% and 10% will be given on selection of 2 year or 3 year tenure policies respectively.
- Loyalty Discount: 5% discount if the client already has our ongoing retail health insurance policy.
- Employee Discount: 10% discount if the client is an employee of the Company. The discount will be given to each member insured under the Policy.
- Direct Policy Purchase Discount-10% discount will be given if you are purchasing this Policy through Our Website / direct channels.

Part VII. GRIEVANCE REDRESSAL PROCEDURE

We are concerned about you and are committed to extend the best possible services. In case you are not satisfied with our services or resolutions, please follow the below steps for redressal.

Step 1	Step 2
<p>Call us on Toll free number: 1800-266-5844 (8:00 AM to 8:00 PM, 7 days of the week) or Email us at: care@libertyinsurance.in or Write to us at: Customer Service Liberty General Insurance Limited 10th Floor, Tower A, Peninsula Business Park, Ganpatrao Kadam Marg, Lower Parel, Mumbai 400 013</p>	<p>If our response or resolution does not meet your expectations, you can escalate at Manager@libertyinsurance.in</p>
	Step 3
	<p>If you are still not satisfied with the resolution provided, you can further escalate at ServiceHead@libertyinsurance.in</p>

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

If the insured person is not satisfied with the redressal of the grievance through one of the above methods, insured person may contact the grievance officer at gro@libertyinsurance.in.

For updated details of grievance officer kindly refer <https://www.libertyinsurance.in/customer-support/grievance-redressal>

If 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. The contact details of the Insurance Ombudsman offices have been provided in Annexure B:

Grievance may also be lodged at IRDAI Integrated Grievance Management System- <https://igms.irda.gov.in/>

BENEFIT SCHEDULE

GENERAL DETAILS	
Age Group	Minimum Age at Entry (Adult) - 18 Years, Children 91 days
	Maximum Age at Entry (Adult) - 65 Years
	Child/Children below 25 years can be insured provided either parent is getting insured under the Policy
Renewal	Life Long
Tenure	1/ 2/ 3 years
Option	Individual Sum Insured basis and Family Floater Sum Insured basis
Family members	Individual Sum Insured- Family members as stated in the Policy schedule can be covered in a single Policy on Individual Sum Insured basis
	Family Floater Basis- Self + Spouse+ max upto 3 dependent children can be covered under a single Sum Insured

HEALTH CONNECT SUPRA POLICY

SUM INSURED AND DEDUCTIBLE (APPLICABLE)					
PLAN		TOP UP		SUPER TOP UP	
OPTION	SUM INSURED	DEDUCTIBLE PER CLAIM/HOSPITALIZATION/ANY ONE ILLNESS	OPTIONS	SUM INSURED	DEDUCTIBLE PER YEAR
I	INR 50000 1, 1.5, 2 LAKHS	INR 50000	I	3, 5, 7, 10,15,20 LAKHS	2 ,3,4,5,7.5,10 LAKHS
II	3, 5,7 LAKHS	2 ,3, 4, 5 LAKHS	II	10 , 15, 20,30,50,100 LAKHS	10, 15,20,30, 40 LAKHS
III	10,15,20 LAKHS	5, 7.5, 10 LAKHS			

COVERAGE(S) DETAILS						
PLAN		TOP UP			SUPER TOP UP	
OPTIONS		I	II	II	I	II
SUM INSURED		INR 50000, 1 Lakh, 1.5 Lakhs, 2 Lakhs	3, 5, 7 Lakhs	10, 15,20 Lakhs	3, 5, 7, 10, 15, 20 Lakhs	10 , 15, 20, 30, 50, 100 Lakhs
DEDUCTIBLE		INR 50000	2, 3, 4, 5 Lakhs	5, 7.5, 10 Lakhs	2, 3, 4, 5, 7.5,10 Lakhs	10, 15, 20, 30,40 Lakhs
In-patient Hospitalization	Minimum 24 Hrs hospitalisation as an In-patient	✓	✓	✓	✓	✓
Pre-Hospitalisation	Medical expenses incurred prior to the covered Hospitalization	30 DAYS	30 DAYS	60 DAYS	30 DAYS	60 DAYS
Post-Hospitalisation	Medical expenses incurred after the covered Hospitalization	60 DAYS	60 DAYS	90 DAYS	60 DAYS	90 DAYS
Day care Procedures	405 day care procedures undertaken in a hospital/day care centre in less than 24 hours due to Technological advancement	✓	✓	✓	✓	✓
Loyalty Perk	Auto increase in Sum Insured by 10% on Sum insured for every claim free year up to max. of 100%.	NA	NA	NA	✓	✓
Preventive Care	The Company will provide benefits which would help in preventing adverse Health condition/s.	✓	✓	✓	✓	✓
OPTIONAL COVER(S)						
Reload of Sum Insured	Reload Sum Insured available when the Sum Insured gets exhausted	NA	✓	✓	✓	✓

HEALTH CONNECT SUPRA POLICY

OPTIONAL COVER(S)						
AYUSH Treatment	Medical expenses incurred for Ayurveda, Unani, Sidha and Homeopathy Treatment	NA	✓	✓	✓	✓
World-wide coverage	Emergency care Medical expenses incurred outside India	NA	NA	NA	✓	✓
Wellness & Assistance Program	Available on optional basis and serviced by Us/Through Our Service Provider	✓	✓	✓	✓	✓
WAITING PERIOD(S)						
30 days	IN INDIA:WAITING PERIODS ARE APPLICABLE Optional Cover WORLD-WIDE COVERAGE: NO WAITING PERIOD APPLICABLE	✓	✓	✓	✓	✓
2 Years	IN INDIA:WAITING PERIODS ARE APPLICABLE Optional Cover WORLD-WIDE COVERAGE: NO WAITING PERIOD APPLICABLE	✓	✓	✓	✓	✓
4 Years	IN INDIA:WAITING PERIODS ARE APPLICABLE Optional Cover WORLD-WIDE COVERAGE: NO WAITING PERIOD APPLICABLE	✓	✓	✓	✓	✓
Pre- existing Diseases (PED)	Yes	3 YEARS	3 YEARS	3 YEARS	3 YEARS	3 YEARS

HEALTH CONNECT SUPRA POLICY

LIST OF DAY CARE PROCEDURES

Day Care Procedures/Treatments include the following Day Care Surgeries & Day Care Treatments and can include other Day Care procedures or surgery or treatment undertaken by the Insured Person as an inpatient for less than 24 hours in a Hospital or standalone day care centre but not in the Outpatient department of a Hospital:

ENT

- 1 Stapedotomy
- 2 Myringoplasty (Type I Tympanoplasty)
- 3 Revision stapedectomy
- 4 Labyrinthectomy for severe Vertigo
- 5 Stapedectomy under GA
- 6 Ossiculoplasty
- 7 Myringotomy with Grommet Insertion
- 8 Tympanoplasty (Type III)
- 9 Stapedectomy under LA
- 10 Revision of the fenestration of the inner ear.
- 11 Tympanoplasty (Type IV)
- 12 Endolymphatic Sac Surgery for Meniere's Disease
- 13 Turbinectomy
- 14 Removal of Tympanic Drain under LA
- 15 Endoscopic Stapedectomy
- 16 Fenestration of the inner ear
- 17 Incision and drainage of perichondritis
- 18 Septoplasty
- 19 Vestibular Nerve section
- 20 Thyroplasty Type I
- 21 Pseudocyst of the Pinna - Excision
- 22 Incision and drainage - Haematoma Auricle
- 23 Tympanoplasty (Type II)
- 24 Keratosis removal under GA
- 25 Reduction of fracture of Nasal Bone
- 26 Excision and destruction of lingual tonsils
- 27 Conchoplasty
- 28 Thyroplasty Type II
- 29 Tracheostomy
- 30 Excision of Angioma Septum
- 31 Turbinoplasty
- 32 Incision & Drainage of Retro Pharyngeal Abscess
- 33 UvuloPalatoPharyngoPlasty
- 34 Palatoplasty
- 35 Tonsillectomy without adenoidectomy
- 36 Adenoidectomy with Grommet insertion
- 37 Adenoidectomy without Grommet insertion
- 38 Vocal Cord lateralisation Procedure
- 39 Incision & Drainage of Para Pharyngeal Abscess
- 40 Transoral incision and drainage of a pharyngeal abscess
- 41 Tonsillectomy with adenoidectomy
- 42 Tracheoplasty

Ophthalmology

- 43 Incision of tear glands
- 44 Other operation on the tear ducts
- 45 Incision of diseased eyelids
- 46 Excision and destruction of the diseased tissue of the eyelid
- 47 Removal of foreign body from the lens of the eye.
- 48 Corrective surgery of the entropion and ectropion
- 49 Operations for pterygium
- 50 Corrective surgery of blepharoptosis

- 51 Removal of foreign body from conjunctiva
- 52 Biopsy of tear gland
- 53 Removal of Foreign body from cornea
- 54 Incision of the cornea
- 55 Other operations on the cornea
- 56 Operation on the canthus and epicanthus
- 57 Removal of foreign body from the orbit and the eye ball.
- 58 Surgery for cataract
- 59 Treatment of retinal lesion
- 60 Removal of foreign body from the posterior chamber of the eye

Oncology

- 61 IV Push Chemotherapy
- 62 HBI-Hemibody Radiotherapy
- 63 Infusional Targeted therapy
- 64 SRT-Stereotactic Arc Therapy
- 65 SC administration of Growth Factors
- 66 Continuous Infusional Chemotherapy
- 67 Infusional Chemotherapy
- 68 CCRT-Concurrent Chemo + RT
- 69 2D Radiotherapy
- 70 3D Conformal Radiotherapy
- 71 IGRT- Image Guided Radiotherapy
- 72 IMRT- Step & Shoot
- 73 Infusional Bisphosphonates
- 74 IMRT- DMLC
- 75 Rotational Arc Therapy
- 76 Tele gamma therapy
- 77 FSRT-Fractionated SRT
- 78 VMAT-Volumetric Modulated Arc Therapy
- 79 SBRT-Stereotactic Body Radiotherapy
- 80 Helical Tomotherapy
- 81 SRS-Stereotactic Radiosurgery
- 82 X-Knife SRS
- 83 Gammaknife SRS
- 84 TBI- Total Body Radiotherapy
- 85 intraluminal Brachytherapy
- 86 Electron Therapy
- 87 TSET-Total Electron Skin Therapy
- 88 Extracorporeal Irradiation of Blood Products
- 89 Telecobalt Therapy
- 90 Telecesium Therapy
- 91 External mould Brachytherapy
- 92 Interstitial Brachytherapy
- 93 Intracavity Brachytherapy
- 94 3D Brachytherapy
- 95 Implant Brachytherapy
- 96 Intravesical Brachytherapy
- 97 Adjuvant Radiotherapy
- 98 Afterloading Catheter Brachytherapy
- 99 Conditioning Radiotherapy for BMT
- 100 Extracorporeal Irradiation to the Homologous Bone grafts

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- 101 Radical chemotherapy
- 102 Neoadjuvant radiotherapy
- 103 LDR Brachytherapy
- 104 Palliative Radiotherapy
- 105 Radical Radiotherapy
- 106 Palliative chemotherapy
- 107 Template Brachytherapy
- 108 Neoadjuvant chemotherapy
- 109 Adjuvant chemotherapy
- 110 Induction chemotherapy
- 111 Consolidation chemotherapy
- 112 Maintenance chemotherapy
- 113 HDR Brachytherapy

Plastic surgery

- 114 Construction skin pedicle flap
- 115 Gluteal pressure ulcer-Excision
- 116 Muscle-skin graft, leg
- 117 Removal of bone for graft
- 118 Muscle-skin graft duct fistula
- 119 Removal cartilage graft
- 120 Myocutaneous flap
- 121 Fibro myocutaneous flap
- 122 Breast reconstruction surgery after mastectomy
- 123 Sling operation for facial palsy
- 124 Split Skin Grafting under RA
- 125 Wolfe skin graft
- 126 Plastic surgery to the floor of the mouth under GA

Urology

- 127 AV fistula - wrist
- 128 URSL with stenting
- 129 URSL with lithotripsy
- 130 CystoscopicLitholapaxy
- 131 ESWL
- 132 Haemodialysis
- 133 Bladder Neck Incision
- 134 Cystoscopy & Biopsy
- 135 Cystoscopy and removal of polyp
- 136 Suprapubic cystostomy
- 137 percutaneous nephrostomy
- 139 Cystoscopy and "SLING" procedure.
- 140 TUNA- prostate
- 141 Excision of urethral diverticulum
- 142 Removal of urethral Stone
- 143 Excision of urethral prolapse
- 144 Mega-ureter reconstruction
- 145 Kidney renoscopy and biopsy
- 146 Ureter endoscopy and treatment
- 147 Vesico ureteric reflux correction
- 148 Surgery for pelvi ureteric junction obstruction
- 149 Anderson hynes operation
- 150 Kidney endoscopy and biopsy
- 151 Paraphimosis surgery
- 152 injury prepuce- circumcision
- 153 Frenular tear repair
- 154 Meatotomy for meatal stenosis
- 155 surgery for fournier's gangrene scrotum
- 156 surgery filarial scrotum
- 157 surgery for watering can perineum
- 158 Repair of penile torsion
- 159 Drainage of prostate abscess

- 160 Orchiectomy
- 161 Cystoscopy and removal of FB

Neurology

- 162 Facial nerve physiotherapy
- 163 Nerve biopsy
- 164 Muscle biopsy
- 165 Epidural steroid injection
- 166 Glycerol rhizotomy
- 167 Spinal cord stimulation
- 168 Motor cortex stimulation
- 169 Stereotactic Radiosurgery
- 170 Percutaneous Cordotomy
- 171 Intrathecal Baclofen therapy
- 172 Entrapment neuropathy Release
- 173 Diagnostic cerebral angiography
- 174 VP shunt
- 175 Ventriculoatrial shunt

Thoracic surgery

- 176 Thoracoscopy and Lung Biopsy
- 177 Excision of cervical sympathetic Chain Thoracoscopic
- 178 Laser Ablation of Barrett's oesophagus
- 179 Pleurodesis
- 180 Thoracoscopy and pleural biopsy
- 181 EBUS + Biopsy
- 182 Thoracoscopy ligation thoracic duct
- 183 Thoracoscopy assisted empyaema drainage

Gastroenterology

- 184 Pancreatic pseudocyst EUS & drainage
- 185 RF ablation for barrett'sOesophagus
- 186 ERCP and papillotomy
- 187 Esophagoscope and sclerosant injection
- 188 EUS + submucosal resection
- 189 Construction of gastrostomy tube
- 190 EUS + aspiration pancreatic cyst
- 191 Small bowel endoscopy (therapeutic)
- 192 Colonoscopy ,lesion removal
- 193 ERCP
- 194 Colonoscopy stenting of stricture
- 195 Percutaneous Endoscopic Gastrostomy
- 196 EUS and pancreatic pseudo cyst drainage
- 197 ERCP and choledochoscopy
- 198 Proctosigmoidoscopy volvulus detorsion
- 199 ERCP and sphincterotomy
- 200 Esophageal stent placement
- 201 ERCP + placement of biliary stents
- 202 Sigmoidoscopy w / stent
- 203 EUS + coeliac node biopsy

General Surgery

- 204 infected keloid excision
- 205 Incision of a pilonidal sinus / abscess
- 206 Axillary lymphadenectomy
- 207 Wound debridement and Cover
- 208 Abscess-Decompression
- 209 Cervical lymphadenectomy
- 210 infected sebaceous cyst
- 211 Inguinal lymphadenectomy
- 212 Incision and drainage of Abscess
- 213 Suturing of lacerations
- 214 Scalp Suturing

HEALTH CONNECT SUPRA POLICY

215 infected lipoma excision
 216 Maximal anal dilatation
 217 Piles
 A)Injection Sclerotherapy
 B)Piles banding
 218 liver Abscess- catheter drainage
 219 Fissure in Ano- fissurectomy
 220 Fibroadenoma breast excision
 221 Oesophageal varices Sclerotherapy
 222 ERCP - pancreatic duct stone removal
 223 Perianal abscess I&D
 225 Fissure in ano sphincterotomy
 226 UGI scopy and Polypectomy oesophagus
 227 Breast abscess I & D
 228 Feeding Gastrostomy
 229 Oesophagoscopy and biopsy of growth oesophagus
 230 UGI scopy and injection of adrenaline, sclerosants
 - bleeding ulcers
 231 ERCP - Bile duct stone removal
 232 Ileostomy closure
 233 Colonoscopy
 234 Polypectomy colon
 235 Splenic abscesses Laparoscopic Drainage
 236 UGI SCOPY and Polypectomy stomach
 237 Rigid Oesophagoscopy for FB removal
 238 Feeding Jejunostomy
 239 Colostomy
 240 Ileostomy
 241 colostomy closure
 242 Submandibular salivary duct stone removal
 243 Pneumatic reduction of intussusception
 244 Varicose veins legs - Injection sclerotherapy
 245 Rigid Oesophagoscopy for Plummer vinson syndrome
 246 Pancreatic Pseudocysts Endoscopic Drainage
 247 ZADEK's Nail bed excision
 248 Subcutaneous mastectomy
 249 Excision of Ranula under GA
 250 Rigid Oesophagoscopy for dilation of benign Strictures
 251 Eversion of Sac
 a) Unilateral
 b)Bilateral
 252 Lord's plication
 253 Jaboulay's Procedure
 254 Scrotoplasty
 255 Surgical treatment of varicocele
 256 Epididymectomy
 257 Circumcision for Trauma
 258 Meatoplasty
 259 Intersphincteric abscess incision and drainage
 260 Psoas Abscess Incision and Drainage
 261 Thyroid abscess Incision and Drainage
 262 TIPS procedure for portal hypertension
 263 Esophageal Growth stent
 264 PAIR Procedure of Hydatid Cyst liver
 265 Tru cut liver biopsy
 266 Photodynamic therapy or esophageal tumour and Lungtumour
 267 Excision of Cervical RIB
 268 laparoscopic reduction of intussusception
 269 Microdochectomy breast
 270 Surgery for fracture Penis
 271 Sentinel node biopsy
 272 Parastomal hernia

273 Revision colostomy
 274 Prolapsed colostomy- Correction
 275 Testicular biopsy
 276 laparoscopic cardiomyotomy(Hellers)
 277 Sentinel node biopsy malignant melanoma
 278 laparoscopic pyloromyotomy(Ramstedt)

Orthopedics

279 Arthroscopic Repair of ACL tear knee
 280 Closed reduction of minor Fractures
 281 Arthroscopic repair of PCL tear knee
 282 Tendon shortening
 283 Arthroscopic Meniscectomy - Knee
 284 Treatment of clavicle dislocation
 285 Arthroscopic meniscus repair
 286 Haemarthrosis knee- lavage
 287 Abscess knee joint drainage
 288 Carpal tunnel release
 289 Closed reduction of minor dislocation
 290 Repair of knee cap tendon
 291 ORIF with K wire fixation- small bones
 292 Release of midfoot joint
 293 ORIF with plating- Small long bones
 294 Implant removal minor
 295 K wire removal
 296 POP application
 297 Closed reduction and external fixation
 298 Arthrotomy Hip joint
 299 Syme's amputation
 300 Arthroplasty
 301 Partial removal of rib
 302 Treatment of sesamoid bone fracture
 303 Shoulder arthroscopy / surgery
 304 Elbow arthroscopy
 305 Amputation of metacarpal bone
 306 Release of thumb contracture
 307 Incision of foot fascia
 308 calcaneum spur hydrocort injection
 309 Ganglion wrist hyalase injection
 310 Partial removal of metatarsal
 311 Repair / graft of foot tendon
 312 Revision/Removal of Knee cap
 313 Amputation follow-up surgery
 314 Exploration of ankle joint
 315 Remove/graft leg bone lesion
 316 Repair/graft achilles tendon
 317 Remove of tissue expander
 318 Biopsy elbow joint lining
 319 Removal of wrist prosthesis
 320 Biopsy finger joint lining
 321 Tendon lengthening
 322 Treatment of shoulder dislocation
 323 Lengthening of hand tendon
 324 Removal of elbow bursa
 325 Fixation of knee joint
 326 Treatment of foot dislocation
 327 Surgery of bunion
 328 intra articular steroid injection
 329 Tendon transfer procedure
 330 Removal of knee cap bursa
 331 Treatment of fracture of ulna
 332 Treatment of scapula fracture
 333 Removal of tumor of arm/ elbow under RA/GA

HEALTH CONNECT SUPRA POLICY

- 334 Repair of ruptured tendon
- 335 Decompress forearm space
- 336 Revision of neck muscle (Torticollis release)
- 337 Lengthening of thigh tendons
- 338 Treatment fracture of radius & ulna
- 339 Repair of knee joint

Paediatric surgery

- 340 Excision Juvenile polyps rectum
- 341 Vaginoplasty
- 342 Dilatation of accidental caustic stricture oesophageal
- 343 Presacral Teratomas Excision
- 344 Removal of vesical stone
- 345 Excision Sigmoid Polyp
- 346 Sternomastoid Tenotomy
- 347 Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
- 348 Excision of soft tissue rhabdomyosarcoma
- 349 Mediastinal lymph node biopsy
- 350 High Orchiectomy for testis tumours
- 351 Excision of cervical teratoma
- 352 Rectal-Myomectomy
- 353 Rectal prolapse (Delorme's procedure)
- 354 Orchidopexy for undescended testis
- 355 Detorsion of torsion Testis
- 356 lap.Abdominal exploration in cryptorchidism
- 357 EUA + biopsy multiple fistula in ano
- 358 Cystic hygroma - Injection treatment
- 359 Excision of fistula-in-ano

Gynaecology

- 360 Hysteroscopic removal of myoma
- 361 D&C
- 362 Hysteroscopic resection of septum
- 363 thermal Cauterisation of Cervix
- 364 MIRENA insertion
- 365 Hysteroscopic adhesiolysis
- 366 LEEP
- 367 Cryocauterisation of Cervix
- 368 Polypectomy Endometrium
- 369 Hysteroscopic resection of fibroid
- 370 LLETZ
- 371 Conization
- 372 polypectomy cervix
- 373 Hysteroscopic resection of endometrial polyp
- 374 Vulval wart excision
- 375 Laparoscopic paraovarian cyst excision
- 376 uterine artery embolization
- 377 Bartholin Cyst excision
- 378 Laparoscopic cystectomy
- 379 Hymenectomy(imperforate Hymen)
- 380 Endometrial ablation
- 381 vaginal wall cyst excision
- 382 Vulval cyst Excision
- 383 Laparoscopic paratubal cyst excision
- 384 Repair of vagina (vaginal atresia)
- 385 Hysteroscopy, removal of myoma
- 386 TURBT
- 387 Ureterocoele repair - congenital internal
- 388 Vaginal mesh For POP
- 389 Laparoscopic Myomectomy
- 390 Surgery for SUI
- 391 Repair recto- vagina fistula
- 392 Pelvic floor repair(excluding Fistula repair)

- 393 URS + LL
- 394 Laparoscopic oophorectomy
- Critical care
- 395 Insert non- tunnel CV cath
- 396 Insert PICC cath(peripherally inserted central catheter)
- 397 Replace PICC cath(peripherally inserted central catheter)
- 398 Insertion catheter, intra anterior
- 399 Insertion of Portacath

Dental

- 400 Splinting of avulsed teeth
- 401 Suturing lacerated lip
- 402 Suturing oral mucosa
- 403 Oral biopsy in case of abnormal tissue presentation
- 404 FNAC
- 405 Smear from oral cavity

Note: The standard exclusions and waiting periods are applicable to all of the above Day Care Procedures depending on the medical condition

HEALTH CONNECT SUPRA POLICY

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

Annexure A

Sl. 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

HEALTH CONNECT SUPRA POLICY

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

Sl. No.	ITEM
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

HEALTH CONNECT SUPRA POLICY

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

Sl. 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	BLANKET/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

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

Sl. 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

Sl. 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\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT

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

Sl. No.	ITEM
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER& STRIPS
18	URINE BAG

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Annexure-B

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

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in

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

Areas of Jurisdiction	Office of the Insurance Ombudsman
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.I.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P.-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in