Liberty General Insurance Ltd.
15th Floor, Unit-1501&1502, Tower 2,
One International Center,
Senapati Bapat Marg,
Prabhadevi, Mumbai- 400013
IRDAI Reg. No.150, CIN: U66000MH2010PLC269656

CUSTOMER INFORMATION SHEET

DESCRIPTION IS ILLUSTRATIVE AND NOT EXHAUSTIVE

Sl. No.	Title	DESCRIPTION	Policy Clause Number
1	Name of the Insurance Product/Policy	**Secure Health Connect**	NA
2	Policy Number		NA
3	Type of Insurance Product/Policy	Indemnity	NA
4	Sum Insured	Individual/Family Floater policy – Insured 1 Insured 2 Insured 3 Insured 4	NA
5		Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your Plan as specified in the Policy Schedule.	

	Policy Coverage (What the policy covers?)	**Policy Plans**			**Secure Basic**	**Secure Elite**	**Secure Supreme**	**Secure Complete**	Part D.1-11 of the Policy.
		Sr. No.	**Coverage's Description**		**Sum Insured 2, 3, 4, 5 lakhs**	**Sum Insured 2, 3, 4, 5, 7.5, 10 lakhs**	**Sum Insured 3, 4, 5, 7.5, 10 lakhs**	**Sum Insured 2, 3, 4, 5, 7.5, 10, 15 lakhs**	
		1	In-patient Hospitalization	Covers Hospitalization expenses for a period more than 24 hours as an In-patient. Room rent/ICU and associated charges available as per the Plan opted.	**Room Rent sub limit:** 1 % of Sum Insured or maximum up to INR 3000/day whichever is lower **ICU sub limit:** 2 % of Sum Insured or maximum up to INR 6000 /day	**Room Rent sub limit:** 1 % of Sum Insured or maximum up to INR 5000/day whichever is lower **ICU sub limit:** 2 % of Sum Insured or maximum up to INR 6000 /day	**Room Rent sub limit:** 1 % of Sum Insured or maximum up to INR 5000/day whichever is lower **ICU sub limit:** 2 % of Sum Insured or maximum up to INR 7500/day	**Room Rent sub limit:** 1 % of Sum Insured or maximum up to INR 2500/day whichever is lower **ICU sub limit:** 2 % of Sum Insured or maximum up to INR 5000/day	

					whichever is lower	whichever is lower	whichever is lower	whichever is lower	
		2	Pre Hospitalization	Medical expenses incurred prior to the covered Hospitalization	30 DAYS	30 DAYS	45 DAYS	30 DAYS	
					Medical Expenses up to 1% of Sum Insured accrued up to	Medical Expenses up to 1% of Sum Insured accrued up to	Medical Expenses up to 1.5% of Sum Insured accrued up to	No Sub limits applicable	

					maximum 30 days.	maximum 30 days.	maximum 45 days.		
		3	PostHospitalization	Medical expenses incurred after the covered Hospitalization	45 DAYS	45 DAYS	60 DAYS	45 DAYS	
					Medical Expenses up to 1 % of Sum Insured accrued up to maximum 45 days.	Medical Expenses up to 1 % of Sum Insured accrued up to maximum 45 days.	Medical Expenses up to 1.5 % of Sum Insured accrued up to maximum 60 days.	No Sub limits applicable	

		4	Day care Procedures	405 day care procedures as listed in the Policy document, undertaken in a hospital/day care Centre in less than 24 hours due to Technological advancement.	√	√	√	√	

		5	Emergency Local Road Ambulance Charges	Emergency Ambulance charges for transfering to the nearest Hospital	1% of SI , subject to max INR 1,000 per Insured per year	1% of SI , subject to max INR 2,000 per Insured per year	1% of SI , subject to max INR 3,000 per Insured per year	X	
		6	Daily Cash Allowance	Daily cash allowance of up to 10th day of continuous hospitalizati on. A deductible of first 48 hours of hospitalizati on is applicable	X	X	X	INR 500 / per day	
		7	Cumulativ e Bonus	Auto increase in Sum Insured for every	Per Year: 10% Max up to 50%	Per Year: 10% Max up to 50%	Per Year: 10% Max up to 50%	Per Year: 25% Max up to 100%	

				claim free year					
		8	Sub limits on Medical Expenses	Disease wise sublimit as per Annexure attached	√	√	√	√	
		9	Co-Pay	Nonnetwork Hospital: 10 % Co-pay Insured above 60 years: 10% Co-Pay	√	√	Co-Pay Not Applicable	√	

		10	Health Check up	Per Insured Person 18 yrs. and above limited to max 2 adult Insured/s, Health Check up at every 2 continuous claim free renewal.	√	√	√	√	
		11	Stay Fit Perks	Additional perks on every block of two claim free Policy renewals with Us as per the SI	SI up to INR 5 Lakh: Lump sum amount of INR 3000	SI up to INR 5 Lakh: Lump sum amount of INR 4000	SI up to INR 5 Lakh: Lump sum amount of INR 5000	SI up to INR 5 Lakh: Lump sum amount of INR 4000	

				and Plan opted. This will be accumulated in your Policy automatically and may be utilized after the 2nd claim free Policy renewal against any deduction as applicable under the Policy		SI above INR 5 Lakh: Lump sum amount of INR 5000	SI above INR 5 Lakh: Lump sum amount of INR 7000	SI above INR 5 Lakh: Lump sum amount of INR 5000	
		12	AYUSH Treatment#	"AYUSH treatment" refers to the medical and / or hospitalization treatments given under	Upto Basic SI	Upto Basic SI	Upto Basic SI	Upto Basic SI	

				Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems. #Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024.					
		Optional Cover(s)							
		1	Reload of Sum Insured	Sum Insured can be reloaded equivalent to the original Sum Insured opted.	√	√	√	√	Part D Optional Covers: 1-3 the Policy

		2	Enhanced Cumulative Bonus	Total Cumulative Bonus (Cumulative Bonus + Optional Cover Cumulative Bonus) per year shall be enhanced by opting this option and as per the Plan opted.	Per Year: 20% Max upto 100%	Per Year: 25% Max upto 100%	Per Year: 30% Max upto 150%	X	
		3	Waiver of Medical Expenses Sub limits	Sub limits as specified in the Annexure are waived off by opting this Optional Cover	√	√	√	√	

6	Exclusions (What the policy does not cover)	**Standard Exclusions** **1. Pre- Existing Diseases** 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 of 36 months or 24 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-exiting Disease is subject to the same being declared at the time of application and accepted by the Insurer. **2. Specified disease/procedure waiting period** "Specific waiting period" means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break. Specified surgeries/treatments/diseases are covered after specific waiting period of 36 months **3. 30-day Waiting Period** a) Expenses related to the treatment of any illness within 30 days from the first policy	Part E.i. of the 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. **4. Investigation & Evaluation** 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** 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 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** 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** 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**	

		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** 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** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations 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. **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.	

		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. **15. Refractive error** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. **16. Unproven Treatments** 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. Sterility and Infertility** Expenses related to sterility and infertility. This includes: (i) Any type of contraception, sterilization (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI (iii) Gestational Surrogacy (iv) Reversal of sterilization **18. Maternity** 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.	

		Specific Exclusions 1. 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 Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind. 2. Any dental treatment or surgery unless requiring hospitalization arising out of an accident. 3. 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. 4. Charges incurred in connection with cost of spectacles and contactlenses, hearing aids, routine eye and ear examinations, dentures, artificial teeth and all other similar external appliances and /or devices whether for diagnosis or treatment. 5. 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. 6. External Congenital Anomaly. 7. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident 9. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy. 10. Treatment received outside India	Part E.ii. of the policy

		11. 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. 12. 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. 13. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness. 14. Personal comfort and convenience items or services including but not limited to 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 as well as similar incidental services and supplies. 15. Expenses related to any kind of RMO charges, service charge, surcharge, admission fees, registration fees, night charges levied by the hospital under whatever head. 16. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion: a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death. b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of	

		any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death. c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and /or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death. 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. 17. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products. 18. Drugs or treatment and medical supplies not supported by a prescription from a Medical Practitioner. **Exclusions specific to AYUSH Treatment#** The Company shall not make payment in respect of claims arising directly or indirectly out of or attributable or traceable to any of the following: • OPD / Day care treatment • Wellness and non-therapeutic treatment • Any Pre-Hospitalization and Post-Hospitalization Expenses • All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary.	

		• Non- Prescribed medicines by treating physician, non-disclosed formulations & non-standardized preparations or Health Supplementary products will be excluded. • Any Pre or Post hospitalization AYUSH treatment taken before/pursuant to inpatient Allopathy treatment. The above exclusions are in additions to the General exclusions listed under the Policy. #Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024	

<table>
<tr><td>7</td><td>Waiting period</td><td>· 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 36 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.</td><td>Part E.i.1,2&3 of the policy</td></tr>
<tr><td>8</td><td>I. Sub-limit (It is pre-defined limit, and the insurance company will not pay any amount in excess of this limit)</td><td>The Medical Expenses incurred during any Hospitalization due to the below listed treatments shall be limited to actual expenses or up to the Sub limits (whichever is less) as stated below. All values are in INR. Excluding taxes.
<table>
<tr><th rowspan="2">Procedure/Treatment</th><th colspan="4">Policy Plans</th></tr>
<tr><th>Secure Basic</th><th>Secure Elite</th><th>Secure Supreme</th><th>Secure Complete</th></tr>
<tr><td>Cataract per eye</td><td>20,000</td><td>30,000</td><td>40,000</td><td>40,000</td></tr>
<tr><td>Hysterectomy</td><td>35,000</td><td>45,000</td><td>55,000</td><td>55,000</td></tr>
<tr><td>Removal of gall bladder</td><td>35,000</td><td>45,000</td><td>55,000</td><td>55,000</td></tr>
<tr><td>Surgery for piles</td><td>20,000</td><td>30,000</td><td>40,000</td><td>40,000</td></tr>
<tr><td>Surgery for fissure, fistula and sinus</td><td>20,000</td><td>30,000</td><td>40,000</td><td>40,000</td></tr>
<tr><td>Surgery for nasal septum correction</td><td>20,000</td><td>30,000</td><td>40,000</td><td>40,000</td></tr>
</table></td><td>Benefit Schedule & Annexure of the Policy</td></tr>
</table>

		Angiography invasive	15,000	20,000	30,000	30,000	
		PTCA	80,000	120,000	150,000	150,000	
		Appendectomy	30,000	40,000	50,000	50,000	
		D & C	10,000	15,000	20,000	20,000	
		Hernia	35,000	45,000	55,000	55,000	
		Deviated Nasal Septum	35,000	45,000	55,000	55,000	
		Surgery for renal stone	35,000	45,000	55,000	55,000	
		Prostate Surgery TURP	75,000	100,000	120,000	120,000	
		CABG	100,000	150,000	200,000	200,000	
		Total Knee replacement per knee	80,000	120,000	150,000	150,000	
		Total Hip replacement	80,000	120,000	150,000	150,000	

		In case of a claim, this policy requires you to share the following costs: Expenses exceeding the following: **Sub-limits** * Room / ICU charges: as per the Policy Plan chosen. * For the following specified diseases: sub-limits are applicable as per the Policy Plan chosen however this is not applicable if selected Optional cover "Waiver of Medical Expenses Sub limits".	
	II. Co-Payment (It is a specified amount/percentage of the admissible claim amount to be paid by policyholder/insured).	**Co-Payment** For all admissible claims in non-network hospitals, Insured shall bear 10% of the admissible claim and in respect of Insured above 60 years, 10% co-pay will be applied on all admissible claims irrespective of network/non-network hospital.	Part D.9.of the policy
	III. Deductible (It is a specified amount – up to which an insurance company will not pay any claim, and which will be deducted from total claim amount (if claim	**Deductible** A deductible of first 48 hours of hospitalization is applicable.	

	amount is more than the specified amount)			
	IV. Any other limit (as applicable)			

9	Claims/Claims procedure	**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. **Turn Around Time (TAT)** for claim settlement: * TAT for preauthorization of cashless facility within 2 Hours. * TAT for cashless final bill authorization within 2 Hours. Link to be provided below for the said details - i. Network Hospital details – https://www.libertyinsurance.in/products/CPMigration/hospitalLocator ii. Helpline number – 1800 266 5844 iii. Claim form – https://www.libertyinsurance.in/customer-support/download-forms.html **Claim Procedure**	Part G.7. of the policy	

		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: i. Policy Number / Health Card No ii. Name of the Insured / Insured Person availing treatment iii. Details of the disease/illness/injury iv. Name and address of the Hospital v. 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 needs 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.		

		b. 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 Hospitalization medical expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorization letter to the health care service provider. ii. For the purpose of considering Pre-Authorization 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. If the claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorization to the Hospital concerned for cashless facility whereby hospitalization medical expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorization. iii. 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 medical expenses and claim reimbursement immediately after discharge from the Hospital. iv. 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. v. 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). **c. 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. Applicable Taxes prevailing at the time of claim will be considered as part of the Claim Amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Sum Insured opted. No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy.		

		d. Claim Service Assurance: Cashless Service Assurance: If the Insured / Insured person notifies a cashless facility request by sending the Pre- Authorization form duly filled in and signed through email, fax to the Company / TPA or its representative then within 6 Hours of the actual receipt of such a request the Company / TPA will respond with: a. Approval, or b. Rejection If such request has been notified during office hours (9am to 6pm) on Monday to Friday and the Company/TPA fails to either approve or reject or seek further information after the expiry of 6 Hours from the actual receipt of such a request then the Company shall be liable to pay the Insured for the delay in the following manner: i. For Delay beyond 6 hours Rs 1500/- ii. The Maximum amount the Company shall be liable to pay for any delay, in respect of a single hospitalization, shall at no time exceed Rs 1500/- The Company will not be liable to make any payments under the above clause in case of any natural event or manmade disturbance which impedes the Company's ability to make a decision or communicate such decision to the Insured/Insured Person. Any amount paid under the Clause will not affect the Sum Insured as specified in the Schedule. That the Company's liability to make payments under the Clause shall at all times be restricted to the amounts		

		specified including the maximum amount specified therein and the Insured shall not be entitled to any sum whatsoever, in excess of those amounts. That any Payment made under this clause by the Company will not account to any admission of liability for a claim notified by the Insured. Service Assurance is applicable only to the first response on a single claim and no subsequent correspondence. **CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM** **In-patient Treatment/ Day Care Procedures** q Duly filled and signed Claim Form q Photocopy of ID card / Photocopy of current year policy q 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 q Original payment Receipt of the hospital bill with receipt number q 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 q Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts q Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same q Original medicine bills and receipts with corresponding Prescriptions. q Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment		

		receipts. Road Traffic Accident **In addition to the In-patient Treatment documents:** q Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate. In Non Medico legal cases q Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained) In Accidental Death cases q Copy of Post Mortem Report (if conducted) & Death Certificate **For Death Cases** In addition to the In-patient Treatment documents: q Original Death Summary from the hospital. q Copy of the Death certificate from treating doctor or the hospital authority. q Copy of the Legal heir certificate (where nomination is not available) **Pre and Post-hospitalisation medical expenses** q Duly filled and signed Claim Form. q Photocopy of ID card / Photocopy of current year policy. q Original Medicine bills, original payment receipt with prescriptions. q Original Investigations bills, original payment receipt with prescriptions and report. q Original Consultation bills, original payment receipt with prescription. q Copy of the Discharge Summary of the main claim.		

		Tele-medicine q A proper invoice or numbered bill of consultation with date q A proof of payment either a Online, G-PAY or Pay-TM q The consultation note or Prescription with Physicians registration number and details q 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:** a) 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. b) If required, the Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense. c) If required, the Insured person must agree to be examined by a medical practitioner of our choice at Our expenses. d) The Policy - excludes the Standard List of excluded items - attached in the Policy document. e) No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy.		

10	Policy Servicing	**Step - 1** Call center number - 1800-266-5844 (8:00 AM to 8:00 PM, 7 days of the week) or Email us at: care@libertyinsurance.in Senior Citizens can email us at - seniorcitizen@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. **Step - 2** If our response or resolution does not meet your expectations, you can escalate at - Manager@libertyinsurance.in **Step - 3** If you are still not satisfied with the resolution provided, you can further escalate at - ServiceHead@libertyinsurance.in	Part F.i.16 of the Policy	

11	Grievances/Complaints	IRDAI Integrated Grievance Management System - https://igms.irda.gov.in Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document.	Annexure -B	

12	Things to remember	**Free Look Cancellation:** The insured person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. The Free Look Period shall be applicable only for new individual health insurance policies, except for those policies with tenure of less than a year and not on renewals. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to - i. 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 ii. 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 iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period; **Policy Renewal:** The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person. i. The Company shall endeavor to give notice for renewal. However, the Company is not under an obligation to give any notice for renewal. ii. Renewal of a health insurance policy shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.	Part F.i.15 of the policy Part F.i.10. of the policy	

		iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period. iv. 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.		

		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 at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. **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 30 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 benefits in waiting periods as per IRDAI guidelines on portability. **Change in Sum Insured** Sum insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the company. For increase in SI, the waiting period if any shall start afresh only for the enhanced portion of the sum insured. **Moratorium Period**	Part F.i.8. of the policy Part F.i.9. of the policy	

		After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract. Note :The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.	Part F.i.12. of the policy	

13	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.	Part F.i.1 & 2	

SECURE HEALTH CONNECT-POLICY WORDINGS

A. POLICY SCHEDULE

The Policy Schedule is enclosed with the Policy document shared with you comprising the benefits and Sum Insured/Limits applicable to every available cover.

B. PREAMBLE

Liberty General 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 and subject to the 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.

C. 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.

i. Standard Definitions (Definitions whose wordings are specified by IRDAI)

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

2. **"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

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

   a. Central or State Government AYUSH Hospital; or

   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

   i. Having at least 5 in-patient beds;

   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

   iii. Having dedicated AYUSH therapy sections as required and

   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.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

ii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

5. **"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 approved

6. **"Condition Precedent"** means a policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

7. "**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**

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

9. " **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-
   a) has qualified nursing staff under its employment;
   b) has qualified medical practitioner(s) in charge;
   c) has a fully equipped operation theater of its own where surgical procedures are carried out;
   d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

10. **"Day care Procedure/Treatment"** means medical treatment, and/or surgical procedure which is –

a) undertaken under General or Local Anesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and
b) which would have otherwise required hospitalization of more than twenty four hours.

Treatment normally taken on an out-patient basis or not included in the list enclosed in the document is not included in the scope of this definition.

11. **"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.

12. **"Dental Treatment**"means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

13. **"Disclosure to information norm"** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

14. "**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.

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

16. **"Hospital -"** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
    iii. has qualified medical practitioner (s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

17. **"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

18. **"Intensive Care Unit (ICU) Charges"** means the amount charged by a Hospital towards ICU expenses 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.

19. **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
   i. **Acute Condition** means a disease, illness or injury that is likely to response quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
   ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
      a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
      b) it needs ongoing or long-term control or relief of symptoms
      c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
      d) it continues indefinitely
      e) it recurs or is likely to recur

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

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

22. **"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

23. **"Medical Advise"**means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription .

24. **"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..

25. **"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.

26. **"Medically Necessary treatment "** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
    i. is required for the medical management of illness or injury suffered by the insured;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner;
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India

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

28. **"Network Provider"** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

29. **"Non-Network Provider "** means any hospital , day care centre or other provider that is not part of the network

30. **"Nominee"** means the person named in the proposal or schedule to whom the benefits under the Policy is nominated by the Insured Person.

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

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

33. **"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. .

34. **"Pre-Existing Disease"** 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.

35. **"Pre-hospitalization Medical expenses"** means Medical Expenses incurred during predefined number of days preceding the hospitalization of the Insured -provided that:
   a) Such Medical Expenses are incurred for the same condition for which the Insured person's Hospitalizations was required, and
   b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

36. **"Post-hospitalization Medical Expenses"** means Medical Expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
   a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
   b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

37. **"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.

38. **"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.

39. **"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.

40. **"Subrogation"** means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source. (Applicable to other than Health Policies and health sections of Travel and PA policies)

41. **"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.

42. **"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..

43. **"Third Party Administrator or 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

44. **"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.

iii. Specific Definitions (Definitions other than those mentioned under C(i) above)

45. **"Age"** means age of the Insured person on last birthday as on date of commencement of the Policy..

46. **"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

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

48"AYUSH 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 or Ayurvedic and or such other authorities 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 its scope and jurisdiction of license and acceptable to Us.

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

50. 50."**Cumulative Bonus"** shall mean any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

51. "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.

52. "Family" means the Insured, his/her lawful spouse, dependent child/children, Parents and/or Parents-in-laws

53. "Family Floater" means Policy wherein all Insured Person/s of a family are covered under a single Sum Insured.

54."Insured/ You/ Your/ Yourself" means an individual, who has proposed for Insurance and on whose name the Policy is issued.

55."**Insured Person/s"** means the person(s) named in the Schedule of the Policy.

"**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

52 **"Policy period"** means the period between the inception date and expiry date of the Policy as specified in the Schedule to this Policy or the date of cancellation of this Policy, whichever is earlier.

53 **"Policy Schedule"** means the Policy Schedule attached to and forming part of Policy.

54 **"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.

55 "**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.

56 **"Room rent"** -means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

57 **"We/Our/Us"** means the Liberty General Insurance Limited

D. BENEFITS COVERED UNDER THE POLICY

SCOPE OF COVER

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse reasonable and customary charges incurred towards medically necessary expenses up to the limits specified in the schedule against each benefit.

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 total sum of basic Sum Insured, Cumulative Bonus and Reload of basic Sum Insured as 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 medical expenses, subject to the terms, conditions, exclusions and definitions contained herein or endorsed.

I. Room, boarding expenses including 'Associated medical expenses' upto the limit specified in the Policy Schedule.
II. Intensive Care Unit bed charges

"Associated medical expenses as specified below:

i. Doctor's fees

ii. Nursing Expenses
iii. Surgical Fees, Operation Theatre Charges, Anesthetist, Anesthesia, Blood, Oxygen and their administration, Physical Therapy

If the Insured Person is admitted in a room where the Room Rent incurred or the Room Category is different than the one specified in the Policy Certificate, then the Policyholder shall bear the rateable proportion of the total associated Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent actually incurred and the room rent limit or the Room Rent of the entitled room category to the room rent actually incurred.

The proportionate deductions would be applied only in case of a hospital that follows differential billing practice based on the room category occupied by the Insured person and any Room rent category other than Intensive Care Unit.

2. **Pre-Hospitalization Expenses**

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

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

3. **Post-Hospitalization Expenses**

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

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalization was required, and
ii. There is a valid claim admissible under Part D 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. **Emergency Local Road Ambulance charges :**

The Company will indemnify expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following Accidental Bodily Injury/ illness / disease occurring during the Policy Period, provided that:

i. Our maximum liability shall be as specified in the Schedule to this Policy.
ii. There is a valid claim admissible under Part D 1(In-patient Treatment Expenses) of the Policy
iii. The coverage also includes the cost of the transportation of the Insured Person from one Hospital to another nearest Hospital which is prepared to admit the Insured Person and provide necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person was first admitted, provided that the transportation has been prescribed by a Medical Practitioner and is Medically Necessary.

6. **Hospital Daily Cash Allowance**

The Company will pay the amount as specified in the Schedule to this Policy against Hospital Cash allowance benefit for each continuous and completed period of 24 hours of hospitalization of the Insured Person for a maximum up to 10th day of continuous hospitalization, provided a valid claim is admissible under Part B.1 (Inpatient Treatment Expenses) of the Policy. A deductible of first 48 hours of hospitalization is applicable.

7. **Cumulative Bonus**

If the policy is claim free and is renewed with us without any break or within the Grace period as defined, there will be an auto increase in Sum Insured by 10% or 25% for every claim free Policy year up to a maximum of 50% or 100% of the Sum Insured depending on the Plan chosen and as stated in the Benefit Schedule. In the event of a Claim occurring during any Policy Year, the accrued Cumulative Bonus will be reduced by 10% or 25% (depending on the Plan chosen) of the expiring Sum Insured at the commencement of next Policy Year, but in no case shall the Sum Insured be reduced.

a. For a Family Floater policy, the Cumulative Bonus 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 Cumulative Bonus 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 Cumulative Bonus 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 Cumulative Bonus in the expiring Policy/ies, and such expiring Policy/ies is renewed with the Company on a Floater Basis, then the Cumulative Bonus carried forward under such renewed floater Policy would be the least of the Cumulative Bonus/s earned under the expiring Policy/ies..

d. Entire Cumulative Bonus will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace period whichever is later.

8. **Sub Limits on Medical Expenses**

The Medical Expenses incurred during any Hospitalisation due to the listed Surgeries / Medical Procedures or any listed medical treatment pertaining to an Illness / Injury shall be limited to actual expenses or upto the Sub limits (whichever is less) as stated in the 'Annexure' attached to the Policy which is inclusive of its related Pre and Post Hospitalization expenses if applicable as specified under Part D. 1, 2 & 3 of the Policy.

9. **Co-Payment**

For all admissible claims in non-network hospitals, Insured shall bear 10% of the admissible claim and in respect of Insured above 60 years, 10% co-pay will be applied on all admissible claims irrespective of network/non-network hospital.

10. **Health Check-up**

The Insured Person/s above18 years of age is/are entitled to a free health check-up as below at a diagnostic center specified by the Company after a block of every 2 claim free years of continuous yearly Policy renewal with Us. This is available for the Insured Person/s who was insured with Us for the above specified period and continue to be insured in the subsequent Policy Year.

a. For a Family Floater policy, Health Check-up shall be available only if no claim has been made in respect of any Insured Person covered during the two expiring Policy Years. The Health Check-up which is accrued during the claim free Policy Years will only be available to those Insured Person/s who were insured in such claim free Policy Years and continue to be insured in the subsequent Policy Year.

b. If the Insured Person/s in the expiring Policy Years are covered on a Floater Basis during the first Policy Year and the Policy has been renewed for such Insured Person/s by splitting the floater Sum Insured into 2 or more individual covers in the second Policy Year, then the Health Check-up benefit shall be available only to those Insured Person/s who were insured in such 2 Policy Years and who had not made any claim during the two expiring Policy Years and continue to be insured in the subsequent Policy Year.

c. If the Insured Person/s in the expiring Policy Years are covered on an Individual basis during the first Policy Year and the Policy has been renewed with the Company on a floater basis in the second Policy Year, then the Health Check-up benefit shall be available only if no claim has been made in respect of any Insured Person covered during the two expiring Policy Years.

Sum Insured	List of Investigation
2- 5 lac	Complete blood Count, , Fasting Blood Sugar, S.Cholestrol, S. Creatinine, ECG
6- 15 lac	Complete blood Count, Routine Urine Analysis, Fasting Blood Sugar, Lipid profile, S. creatinine, ECG

11. **Stay Fit Perks**

The Policy provides additional perk equivalent to the amount specified in the Benefit schedule applicable on renewal of Policy after every two claim free years subject to Claim admissible under Part II.1 of the Policy. The accumulated Stay fit perk can be utilised from the third policy year against any non-medical expenses, Co-Pay or Sub limits on medical expenses as applicable under the Policy

d. For a Family Floater policy, Stay Fit Perk shall be available only on floater basis and shall accrue only if no claim has been made in respect of any Insured Person covered during the two expiring Policy Years. The Stay Fit Perk which is accrued during the claim free Policy Years will only be available to those Insured Person/s who were insured in such claim free Policy Years and continue to be insured in the subsequent Policy Year.

e. 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 Stay Fit 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.

f. If the Insured Person/s in the expiring Policy are covered on an Individual basis and thereby enjoy separate Stay Fit Perk in the expiring Policy/ies, and such expiring Policy/ies is renewed with the Company on a Floater Basis, then the Stay Fit Perk carried forward under such renewed floater Policy would be the least of the Stay Fit Perk /s earned under the expiring Policy/ies.

12. **AYUSH Treatment#**

The Company will indemnify Reasonable and Customary charges up to the Basic Sum Insured mentioned in the Policy Schedule, towards Medical Expenses incurred for the inpatient hospitalization treatment taken under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy provided that the hospitalization is for minimum 24 hours and is not for evaluation and/or investigation purpose only and treatment is availed in India and provided the treatment has undergone in:

i. Government hospital or in any institute recognized by government and/or accredited by Quality Council of India or National Accreditation Board on Health;
ii. Teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH);
iii. AYUSH Hospitals as defined hereinabove.

#Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024.

Exclusions specific to AYUSH Treatment

The Company shall not make payment in respect of claims arising directly or indirectly out of or attributable or traceable to any of the following:

• OPD / Day care treatment

• Wellness and non-therapeutic treatment

• Any Pre-Hospitalization and Post-Hospitalization Expenses

• All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary.

• Non- Prescribed medicines by treating physician, non-disclosed formulations & non-standardized preparations or Health Supplementary products will be excluded.

• Any Pre or Post hospitalization AYUSH treatment taken before/pursuant to inpatient Allopathy treatment.

The above exclusions are in additions to the General exclusions listed under the Policy

#Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024.

OPTIONAL COVER(S)

The Optional Covers as stated below shall be available only if the same is specifically mentioned in the Policy Schedule and available on payment of additional 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.

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 of the Sum Insured, Cumulative Bonus and Reload Sum Insured as available to the Insured and stated in the Policy Schedule.

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse reasonable and customary charges incurred towards medically necessary expenses up to the limits specified in the schedule against each benefit

1. Reload of Sum Insured

When the original 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:

a. 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;
b. The Reload Sum Insured is available for the medical expenses incurred only in India
c. 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 as stated under Part II 'Scope of cover' of the Policy.
d. The Reload Sum Insured will be available during the Policy Year till it is exhausted completely.
e. Any unutilized Reload amount cannot be carried forward to any subsequent Policy Year/renewal of the Policy.
f. In case of Portability, the credit for Sum Insured would be given only to the extent of the original Sum Insured.

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. Enhanced Cumulative Bonus

The Cumulative Bonus as available under Part D (Scope of Cover) can be enhanced maximum upto 150% of the Sum Insured or as stated under the Policy Schedule (whichever is lower) provided that:

a. The total Cumulative Bonus available under the Policy shall be subject to per Policy Year and maximum upto the limits as per the Plan opted and available under the Policy Schedule,
b. We would not pay separate Cumulative Bonus as stated under Part D.7 ' Cumulative Bonus' of the Policy,
c. The eligibility of this benefit is as per the terms and conditions stated under Part D.7 'Cumulative Bonus' of the Policy.

3. Waiver of the Medical Expenses Sub limits

Notwithstanding anything to the contrary in the Policy, the Company agrees to waive off the sub limits applicable on the listed illnesses/injuries as mentioned under Part D. 8 (Sub Limits on Medical Expenses) subject to the Sum Insured being the Maximum Limit of Indemnity.

E. EXCLUSIONS

The Company shall bear no liability to make the payment in respect of claims arising directly or indirectly out of or attributable or traceable to any of the following:

i. Standard Exclusions (Exclusions for which standard wordings are specified by IRDAI)

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 of 36 months or 24 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-exiting 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.
f. List of specific diseases/procedures

Sr. No.	Two Year (24 months) Waiting Period	Four Year (36 months) Waiting Period
1.	Cataract	Surgical treatment of Obesity
2.	Benign Prostatic Hypertrophy	
3.	Hernia	
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 Gall bladder and Urogenital system	
19	Joint Replacement due to Degenerative condition	
20	Surgery for prolapsed inter vertebral disc unless arising from accident	
21	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: Coronory Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal bleed/Haemorrhages.	
26	Treatment for correction of eye sight (laser surgery) due to refractive error	
*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.		

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.

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- Exc*l* 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 life threatening situations 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 dioptres.

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

ii. Specific Exclusions (Exclusions other than those mentioned under E(i) above)

1. 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 Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or

condition of a similar kind.

2. Any dental treatment or surgery unless requiring hospitalization arising out of an accident.

3. 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.

4. Charges incurred in connection with cost of spectacles and contactlenses, hearing aids, routine eye and ear examinations, dentures, artificial teeth and all other similar external appliances and /or devices whether for diagnosis or treatment.

5. 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.

6. .External Congenital Anomaly.

7. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident

8. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy.

9. Treatment received outside India

10. 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.

11. 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.

12. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.

13. Personal comfort and convenience items or services including but not limited to 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 as well as similar incidental services and supplies.

14. Expenses related to any kind of RMO charges, service charge, surcharge, admission fees, registration fees, night charges levied by the hospital under whatever head.

15. 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:

16. 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.

17. 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.

18. 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

    a. 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.

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

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

F. GENERAL TERMS AND CONDITIONS

i. Standard General Terms and Clauses (General terms and clauses whose wordings are specified by IRDAI)

a. Disclosure of information

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

b. Condition Precedent to admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

c. Claim Settlement (Provision for Penal Interest)

a. 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.
b. 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.
c. 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.
d. 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 Indian (RBI) at the beginning of the financial year in which the claim has fallen due.

d. Complete Discharge

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

e. Multiple Policies

a) Indemnity based policies : In case of multiple policies held by Insured person, insured person has a choice to file claim settlement under any policy. if insured person chooses to file such claim under policy held with with the Company, then same shall be treated as the primary Insurer. In case the available coverage under the said policy is less than the admissible claim amount, then we, Liberty General Insurance as primary Insurer shall seek the details of other available policies of the Insured and shall coordinate

with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the Insured.

b) Benefit based Policies:

On occurrence of the insured event, the policyholders can claim from all Insurers under all policies

f. 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:

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

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

g. Cancellation/Termination

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

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

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

(ii) 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.

h. Migration

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

Insured person can opt for migration of his/her policy to another product with the same Insurer. The insured (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy

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/

i. Portability

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

The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc from the Existing Insurer in the previous policy to the Acquiring Insurer.

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 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. lf such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an lndian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

j. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under an obligation to give any notice for renewal.

ii. Renewal of a health insurance policy shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. 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. **Withdrawal of Policy**

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.

k. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

Note :The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

m. Premium Payments in Installments

i. The grace period of fifteen days (where premium is paid in monthly installments) and thirty days (where premium is paid in quarterly/half-yearly/annual installments) is available on the premium due date, is available to the policyholder to pay the premium.

ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

iii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.

iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.

v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vi. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Given below are the payment terms applicable on standard premiums in case of installments.

Installment Frequency	% of Annual Premium
Half Yearly	51%
Quarterly	26%
Monthly	8.75%

n. 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.

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 underwriting policy.

We are not under any obligation to Renew your Policy on same terms or premium as the expiring Policy. Any change in benefit or premium (other than due to change in Age) will be done with the approval of the IRDA and will be intimated to You

		Waiting period to be served with new insurer in number of days/years upon Portability		
Sl No	No of years of continuous insurance cover with previous insurer(s)	30 days waiting period	2 years waiting period	3 years waiting period for PED
1	1 Year	NIL	1 Year	2 Yearsno
2	2 Years	NIL	NIL	1 Years
3	3 Years	NIL	NIL	0 Year

4	4 Years	NIL	NIL	NIL

o. Free Look Period

The insured person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. The Free Look Period shall be applicable only for new individual health insurance policies, except for those policies with tenure of less than a year and not on renewals.

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

i. 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

ii. 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

ii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

n. Redressal of Grievance

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

Step 1	**Step 2**
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 **Senior Citizens can email us at**: seniorcitizen@libertyinsurance.in or	If our response or resolution does not meet your expectations, you can escalate at Manager@libertyinsurance.in **Step 3** If you are still not satisfied with the resolution provided, you can further

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	escalate at ServiceHead@libertyinsurance.in

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/

The updated grievances redressal procedure shall be provided on the website of the Company and is subject to change in compliance with guidelines/regulations issued by Insurance Regulatory and Development Authority of India.

o. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. ln 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.

iii. Specific terms and clauses (terms and clauses other than those mentioned under F(i) above

1. **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.

2. **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.

3. **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.

4. **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.

5. **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.

6. **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.

7. **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.

8. **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.

9. Electronic Transaction

The Insured agrees to adhere to and comply with all such terms, conditions and exclusions as the Company may prescribe from time to time, and hereby agrees and validates that all 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 the Policy or its terms, or the Company's other products and services, has his concurrence and full understanding of the terms and conditions affecting this Contract and shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure adherence to conditions of section 41 of the Insurance Act 1938 with full disclosures on terms, conditions and exclusions. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and sent to the Insured Person, duly validated/confirmed by the Insured Person.

10. **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 Limited
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.

11. **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.

G. OTHER TERMS AND CONDITIONS:

1. **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 parents is insured under the policy.

2. **For 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.
3. **Increase in Sum Insured or Change in Plan/Optional Cover–** Sum Insured can be enhanced or Policy Plan or Optional Covers 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

4. **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.

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

   In all such cases, we would send a communication letter to the Proposer and obtain his/her consent before acceptance of the Proposal.

5. **Pre Policy Health Check Up-** The Company may require Individuals to undergo Pre Policy health check-up based on the Sum Insured or age bands or an adverse medical history revealed in the Proposal form 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).

6. 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.

   1. 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
   2. 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 subject to in receipt of the applicable premium in advance as single premium.
3. Employee Discount/: 10% discount if the client is an employee of the Company
   4. Direct Policy Purchase Discount- 10% discount will be given if you are purchasing this Policy through Our Website.

7. Claim Process and Management

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:

i. Policy Number / Health Card No
ii. Name of the Insured / Insured Person availing treatment
iii. Details of the disease/illness/injury
iv. Name and address of the Hospital
v. 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 needs 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.

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 Hospitalization medical expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorization letter to the health care service provider.
ii. For the purpose of considering Pre-Authorization 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. If the

claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorization to the Hospital concerned for cashless facility whereby hospitalization medical expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorization.

iii. 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 medical expenses and claim reimbursement immediately after discharge from the Hospital.

iv. 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.

v. 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.

Applicable Taxes prevailing at the time of claim will be considered as part of the Claim Amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Sum Insured opted.

No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy.

c) Claim Service Assurance:

Cashless Service Assurance: If the Insured / Insured person notifies a cashless facility request by sending the Pre- Authorization form duly filled in and signed through email, fax to the Company / TPA or its representative then within 6 Hours of the actual receipt of such a request the Company / TPA will respond with:

i. Approval, or
ii. Rejection

If such request has been notified during office hours (9am to 6pm) on Monday to Friday and the Company/TPA fails to either approve or reject or seek further information after the expiry of 6 Hours from the actual receipt of such a request then the Company shall be liable to pay the Insured for the delay in the following manner:

i. For Delay beyond 6 hours Rs 1500/-
ii. The Maximum amount the Company shall be liable to pay for any delay, in respect of a single hospitalization, shall at no time exceed Rs 1500/-

The Company will not be liable to make any payments under the above clause in case of any natural event or manmade disturbance which impedes the Company's ability to make a decision or communicate such decision to the Insured/Insured Person.

Any amount paid under the Clause will not affect the Sum Insured as specified in the Schedule. That the Company's liability to make payments under the Clause shall at all times be restricted to the amounts specified including the maximum amount specified therein and the Insured shall not be entitled to any sum whatsoever, in excess of those amounts. That any Payment made under this clause by the Company will not account to any admission of liability for a claim notified by the Insured. Service Assurance is applicable only to the first response on a single claim and no subsequent correspondence.

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.

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 medical 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:

a) 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.
b) If required, the Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense.
c) If required, the Insured person must agree to be examined by a medical practitioner of our choice at Our expenses.
d) The Policy - excludes the Standard List of excluded items - attached in the Policy document.
e) Claim settlement (provision for Penal Provision)
    i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

("Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

f) No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy

SECURE HEALTH CONNECT: BENEFIT SCHEDULE

GENERAL DETAILS	
Age Group	Minimum Age at Entry (Adult) - 18 Years
	Maximum Age at Entry (Adult) - 65 Years
	Children between 91 days and 25 years can be insured provided either parent is getting insured under the Policy
Sum Insured	2 lakh – 15 lakh
Renewal	Life Long
Family discount	10% if two or more family members are covered on Individual Sum Insured basis
Tenure	1/ 2/ 3 years
Option	Individual Or Family Floater Sum Insured basis
Family members	**Individual Sum Insured-** Family members as stated in the Policy schedule can cover in a single Policy on Individual Sum Insured basis
	Family Floater Basis- Self + Spouse+ max up to 3 children can be covered under a single Sum Insured.

Policy Plans			**Secure Basic**	**Secure Elite**	**Secure Supreme**	**Secure Complete**
Sr. No	**Coverage's Description**		**Sum Insured 2,3,4,5 lakhs**	**Sum Insured 2,3,4,5,7.5,10 lakhs**	**Sum Insured 3,4,5,7.5,10 lakh**	**Sum Insured 2,3,4,5,7.5,10,15 lakh**
1	In-patient Hospitalization	Covers Hospitalization medical expenses for a period more than 24 hours as an In-patient. Room rent/ICU and associated charges available as per the Plan opted.	**Room Rent sub limit:** 1 % of Sum Insured or maximum up to INR 3000/day whichever is lower **ICU sub limit:** 2 % of Sum Insured or maximum up to INR 6000/day	**Room Rent sub limit:** 1 % of Sum Insured or maximum up to INR 5000/day whichever is lower **ICU sub limit:** 2 % of Sum Insured or maximum up to INR 6000/day	**Room Rent sub limit:** 1 % of Sum Insured or maximum up to INR 5000/day whichever is lower **ICU sub limit:** 2 % of Sum Insured or maximum up to INR 7500/day whichever is lower	**Room Rent sub limit:** 1 % of Sum Insured or maximum up to INR 2500/day whichever is lower **ICU sub limit:** 2 % of Sum Insured or maximum up to INR 5000/day

			whichever is lower	whichever is lower		whichever is lower
2	Pre-Hospitalization	Medical expenses incurred prior to the covered Hospitalization	30 DAYS	30 DAYS	45 DAYS	30 DAYS
			Medical Expenses up to 1% of Sum Insured accrued up to maximum 30 days.	Medical Expenses up to 1% of Sum Insured accrued up to maximum 30 days.	Medical Expenses up to 1.5% of Sum Insured accrued up to maximum 45 days.	No Sub limits applicable
3	Post-Hospitalization	Medical expenses incurred after the covered Hospitalization	45 DAYS	45 DAYS	60 DAYS	45 DAYS
			Medical Expenses up to 1 % of Sum Insured accrued up to maximum 45 days.	Medical Expenses up to 1 % of Sum Insured accrued up to maximum 45 days.	Medical Expenses up to 1.5 % of Sum Insured accrued up to maximum 60 days.	No Sub limits applicable
4	Day care Procedures	405 day care procedures undertaken in a hospital/day care Centre in less than 24 hours due to Technological advancement	√	√	√	√
5	Emergency Local Road Ambulance Charges	Emergency Ambulance charges for transferring to the nearest Hospital	1% of SI , subject to max INR 1,000 per Insured per year	1% of SI , subject to max INR 2,000 per Insured per year	1% of SI , subject to max INR 3,000 per Insured per year	√
6	Daily Cash Allowance	Daily cash of allowance up to 10th day of continuous hospitalization. A deductible of first	√	√	√	INR 500 / per day

		48 hours of hospitalization is applicable				
7	Cumulative Bonus	Auto increase in Sum Insured for every claim free year	Per Year: 10% Max up to 50%	Per Year: 10% Max up to 50%	Per Year: 10% Max up to 50%	Per Year: 25% Max up to 100%
8	Sub limits on Medical Expenses	Disease wise sublimit as per Annexure attached	√	√	√	√
9	Co-pay	Non-network Hospital: 10 % Co-pay Insured above 60 years: 10% Co-Pay	√	√	Co-Pay Not Applicable	√
10	Health Check up	Per Insured Person 18 yrs. and above limited to max 2 adult Insured/s, Health Check up at every 2 continuous claim free renewal.	√	√	√	√
11	Stay Fit Perks	Additional perks on every block of two claim free Policy renewals with Us as per the SI and Plan opted. This will be accumulated in your Policy automatically and may be utilized after the 2nd claim free Policy renewal against any non-medical expenses, Co-Pay or	SI up to INR 5 Lakh: Lump sum amount of INR 3000	SI up to INR 5 Lakh: Lump sum amount of INR 4000	SI up to INR 5 Lakh: Lump sum amount of INR 5000	SI up to INR 5 Lakh: Lump sum amount of INR 4000
				SI above INR 5 Lakh: Lump sum amount of INR 5000	SI above INR 5 Lakh: Lump sum amount of INR 7000	SI above INR 5 Lakh: Lump sum amount of INR 5000

		Sub limits as applicable under the Policy				
12	AYUSH Treatment #	"AYUSH treatment" refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems. #Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024.	Upto Basic SI	Upto Basic SI	Upto Basic SI	Upto Basic SI
Optional Cover (s)						
1	Reload of Sum Insured	Sum Insured can be reloaded equivalent to the original Sum Insured opted.	√	√	√	√
2	Enhanced Cumulative Bonus	Total Cumulative Bonus (Cumulative Bonus + Optional Cover Cumulative Bonus) per year shall be enhanced by opting this option and as per the Plan opted.	Per Year: 20% Max upto 100%	Per Year: 25% Max upto 100%	Per Year: 30% Max upto 150%	×
3	Waiver of Medical Expenses Sub limits	Sub limits as specified in the Annexure are waived off by opting this Optional Cover	√	√	√	√
Waiting Period(s)						

1	30 days	30 days	√	√	√	√
2	2 Years	2 Years	√	√	√	√
3	4 Years	4 Years	√	√	√	√
3	Pre- existing Diseases (PED)	4 Years	√	√	√	√

SUB LIMITS ON MEDICAL EXPENSES

The Medical Expenses incurred during any Hospitalization due to the below listed treatments shall be limited to actual expenses or up to the Sub limits (whichever is less) as stated below. All values are in INR. Excluding taxes.				
Procedure/Treatment	**Policy Plans**			
	Secure Basic	**Secure Elite**	**Secure Supreme**	**Secure Complete**
Cataract per eye	20,000	30,000	40,000	40,000
Hysterectomy	35,000	45,000	55,000	55,000
Removal of gall bladder	35,000	45,000	55,000	55,000
Surgery for piles	20,000	30,000	40,000	40,000
Surgery for fissure, fistula and sinus	20,000	30,000	40,000	40,000
Surgery for nasal septum correction	20,000	30,000	40,000	40,000
Angiography invasive	15,000	20,000	30,000	30,000
PTCA	80,000	120,000	150,000	150,000
Appendectomy	30,000	40,000	50,000	50,000
D & C	10,000	15,000	20,000	20,000
Hernia	35,000	45,000	55,000	55,000
Deviated Nasal Septum	35,000	45,000	55,000	55,000
Surgery for renal stone	35,000	45,000	55,000	55,000
Prostate Surgery TURP	75,000	100,000	120,000	120,000
CABG	100,000	150,000	200,000	200,000
Total Knee replacement per knee	80,000	120,000	150,000	150,000
Total Hip replacement	80,000	120,000	150,000	150,000

LIST OF DAY CARE PROCEDURES/TREATMENTS

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 Uvulo Palato Pharyngo Plasty
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 Radiothearpy for BMT
100 Extracorporeal Irradiation to the Homologous Bone grafts
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 Cystoscopic Litholapaxy
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's Oesophagus
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 Colonscopy 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
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 Lung tumour
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
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 Orchidectomy 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

STANDARD LIST OF EXCLUDED ITEMS

Annexure -A

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

SI. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR

45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

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

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
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION⁄STERILLIUM
17	Glucometer& Strips
18	URINE BAG

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, Ist 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
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.l.: 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, Sonbhabdra, 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