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

Liberty Health Connect Policy

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

Part I: Definitions

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/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. **AYUSH Day Care Centre:**
AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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.

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

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

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

10. "**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

11. **"Day care Procedure/Treatment"** means medical treatment, and/or surgical procedure which is –
    i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than twenty four (24) hours because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than twenty four (24) hours.

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

12. **"Deductible"** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

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

14. **"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.

15. **"Domiciliary Hospitalisation"** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i. the condition of the patient is such that he/she is not in a condition to be moved to a hospital or,
    ii. the patient takes treatment at home on account of non-availability of room in a hospital.

16. "**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.

17. **"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.

18. **"Hospital"** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the

enactments specified under 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 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 makes these accessible to the insurance company's authorized personnel.

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

20. **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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 specially trained to cope with it
        d) it continues indefinitely
        e) it recurs or is likely to recur

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

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

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

24. **"ICU Charges"** ICU (Intensive Care Unit) 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.

25. **"Maternity expenses"**

Maternity expenses means;

a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b) expenses towards lawful medical termination of pregnancy during the policy period.

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

27. **"Medical Practitioner"** A Medical Practitioner is 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 license provided that this person is not a member of the Insured Person's family.

28. **"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.

29. **"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.

30. **"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.

31. **"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.

32. **"New Born Baby"** means baby born during the Policy Period and is aged upto90 days

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

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

35. **"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

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

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

37. **"Pre-hospitalization"** means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
    ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

38. **Post-hospitalization Medical Expenses"** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
    ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

39. **"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.

40. **"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.

41. **"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.

42. **"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.

43. **"Room rent"** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

44. **"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.

45. **"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.

46. **"Unproven/Experimental treatment"** Treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

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

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

2. **"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.

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

4. **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.

5. **"Basic Sum Insured"** means the amount specified against each Insured Person/s specified in the Schedule to this Policy, subject to terms, conditions and exclusions of this Policy.
For policies with more than one year tenure, the Basic Sum Insured specified on the Policy is the limit for each year. This limit will lapse at the end of every year and fresh limits up to the full Basic Sum Insured as opted, will be available for the next year.

6. **"Break in Policy"** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
7. **"Dependent Child"** refers to a child (naturally or legally adopted), who is financially dependent on the Primary Insured or Proposer and does not have his/her independent sources of income between the age of 91 days and eighteen (18) years, or up to and including the age of twenty-five (25) years if undergoing full time education at an accredited educational institution.

8. **"EMI" or EMI Amount** means the fixed payment amount required to repay the principal amount of Loan and Interest by the Insured at a specified date each calendar month, as set forth in the amortization chart referred to in the Loan agreement (or any amendments thereto) between the Bank/Financial Institution and the Insured prior to the date of occurrence of the Insured Event under this Policy. For the purpose of avoidance of doubt, it is clarified that any monthly payments that are overdue and unpaid by the Insured prior to

the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.

9. **"End-of-Life care Treatment**" refers to health care or Palliative care provided in the time leading up to a person's death as confirmed/prescribed by Attending Medical Practitioner. End-of-life care can be provided in the hours, days, or months before a person dies and encompasses care and support for a person's mental and emotional needs, physical comfort, spiritual needs, and practical tasks.

10. "**Family/Family Member"** means the Primary Insured Person whose name forms the first Insured Person, his/her lawful spouse, child/children, parents/ parent-in-laws and such other persons who are specifically mentioned in the Schedule to this Policy.

11. **"Family Floater"** means Policy wherein all Insured Person/s of a family are covered under a single Basic Sum Insured. Basic Sum Insured for family floater policy is the amount specified in the Policy Schedule which represents the Company's maximum total & cumulative liability for all Insured Person/s for any or all claims incurred during the Policy Period excluding Cumulative Bonus, Cumulative Bonus Enhancer, Restore Sum Insured, Capital Sum Insured and specific limits as available to the Insured Person/s as stated in the Policy Schedule.

12. **"Financial Institution"** shall have the same meaning assigned to the term under section 45 I of the Reserve Bank of India Act, 1934 and shall include a Non-Banking Financial Company as defined under section 45 I of the Reserve Bank of India Act, 1934.

13. **"Insured"** means an individual, a Resident Indian, who has proposed for Insurance and on whose name the Policy is issued.

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

15. **"Nominee"** means the person named in the Proposal or Schedule to whom the benefits under the Policy is nominated by the Insured Person.

16. **"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.

17. **"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.

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

19. **"Policy year" mea**ns 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.

20. **"Principal Outstanding"** means the principal amount of the Loan outstanding as on the date of occurrence of Insured Event less the portion of principal component included in the EMIs payable but not paid from the date of the loan agreement till the date of the Insured Event/s. For the purpose of avoidance of doubt, it is clarified that any EMIs that are overdue and unpaid to the Bank prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.

21. **"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.

22. **"Vector-borne Diseases"** is a group of globally distributed and rapidly spreading serious diseases that are caused by vectors. These vectors are organism transmitting pathogens and parasites from one infected organism to another. For this Insurance Policy purpose, the group of ' Vector-borne Diseases' are as per the list provided in the Policy document.

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

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

25. **"You/Your"** means the Insured named in the Schedule who has concluded this Policy with Us.

Part II: Scope of Cover

D. BENEFITS COVERED UNDER THE POLICY

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse actual expenses incurred or up to the limits specified in the schedule against each benefit whichever is less.
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, earned Cumulative Bonus, 'Restoration of Basic Sum Insured' and 'Domestic Travel Plus' as stated in the Policy Schedule.

1. Hospitalisation Expenses

a. In-Patient Treatment Expenses

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

1. Room, Boarding expenses
2. Intensive Care Unit bed charges
3. Doctor's fees
4. Nursing Expenses

5. Surgical Fees, Operation Theatre Charges, Anesthetist, Anesthesia, Blood, Oxygen and their administration, Physical Therapy
6. Prescribed Drugs and medicines consumed on the premises
7. Investigation Services such as Laboratory, X-Ray, Diagnostic tests
8. Dressing, Ordinary splints and plaster casts
9. Cost of Prosthetic devices if implanted during a surgical procedure

b. Day Care Procedure/Treatment

The Company will indemnify medical expenses incurred on a treatment towards a Day Care procedure, 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.

2. Pre-Hospitalisation Expenses

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

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

3. Post-Hospitalisation Expenses

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

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

4. Domiciliary Hospitalisation Treatment

The Company will indemnify medical expenses incurred by an Insured Person/s for Domiciliary Hospitalization treatment taken at his home in India limited to 10% of the Basic Sum Insured for a Policy year.

No payment will be made if the condition for which the Insured Person requires medical treatment is:

a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract
b. Infection including Laryngitis and Pharyngitis, Cough and
c. Cold, Influenza,
d. Arthritis, Gout and Rheumatism,
e. Chronic Nephritis and Nephritic Syndrome,
f. Diarrhoea and all type of Dysenteries including Gastroenteritis,
g. Diabetes Mellitus and Insipidus,
h. Epilepsy,
i. Hypertension,
j. Psychiatric or Psychosomatic Disorders of all kinds
k. Pyrexia of unknown Origin.

5. 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 II 1.a (In-patient Treatment Expenses) of the Policy. A deductible of first 48 hours of hospitalization is applicable.

6. 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 II 1.a (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.

7. Organ Donor Expenses

The Company will indemnify organ donor's screening charges & the medical expenses for an organ donor's treatment for harvesting of the organ donated up to the amount as specified in the Schedule to this Policy, provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 (Amended)and the organ donated is for the use of the Insured Person, and
ii. We will not pay the donor's pre- and post-hospitalisation expenses or any other medical treatment for the donor consequent on the harvesting, and
iii. A valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

8. Second Medical Opinion

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

i. This benefit can be availed only once in a Policy year for the Insured Person
ii. The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained, whether or not to act on the same.
iii. The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Medical Opinion or for any consequences of actions taken or not taken in reliance thereon
iv. Any Second Medical Opinion provided under the Benefit shall not be valid for any medico-legal purposes.

9. Recovery Benefit

The Policy provides for payment to the Insured Person of the sum as specified in the Schedule to this Policy in the event of his / her hospitalization for a continuous period of not less than

10 days subject to a valid claim being admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.
In case of a family floater, this benefit is applicable, separately, to all the members of the policy irrespective of the number of occurrences during the Policy Period subject to overall limit of the Basic Sum Insured.

10. Nursing Allowance

This benefit provides for payment of a daily allowance, as specified in the Schedule to this Policy, towards engaging the services of a qualified nurse either at the Hospital or at the Insured Person's residence provided
- such services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to a disease / illness / injury for which the Insured Person has been hospitalized.
- A valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy
- A deductible of first 48 hours of hospitalization is applicable for Any One Illness/injury.

11. Restoration of Sum Insured

The Policy provides, as applicable to the relevant plan specified in the schedule to the policy, that, where the Basic Sum Insured is exhausted due to claims made and paid during the Policy Year or made during the Policy Year and accepted as payable, then the Company agrees to automatically make available a Restore Sum Insured equal to 100% of the Basic Sum Insured for the particular policy year, provided that:

a. The Restored Sum Insured will be utilized only after the Basic Sum Insured and Loyalty Perk earned if any have been completely exhausted in that Policy Period; and
b. The Restored Sum Insured cannot be clubbed with balance if any available under the Basic Sum Insured and loyalty perk earned if any.
c. The Restored Sum Insured can be used only for such claims as is admissible in terms of Part II-1 of the Policy.
d. The Restored Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an illness/disease for which a claim has been paid in the current policy year under Part II-1 of the Policy.
e. The Restored Sum Insured will be available during the Policy Year till it is exhausted completely.
f. Any unutilized restored amount cannot be carried forward to any subsequent Policy Year.
g. The Restored Sum Insured shall not be considered while calculating the Loyalty Perk/Super Booster cover offered on Optional basis.
h. The total amount of restored Sum Insured shall not exceed the Basic Sum Insured for that Policy Year.
i. In case of Portability, the credit for Sum Insured would be only to the extent of the Basic Sum Insured.

If the policy is a Family Floater, then the Restored Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Basic Sum Insured was exhausted and for whom we have not incurred or paid any claim during the current Policy Period.

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.

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:

1. OPD / Day care treatment
2. Wellness and non-therapeutic treatment
3. Any Pre-Hospitalization and Post-Hospitalization Expenses

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

4. All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary.
5. Non- Prescribed medicines by treating physician, non-disclosed formulations & non-standardized preparations or Health Supplementary products will be excluded.
6. 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.

13. Extended Policy tenure

In case the Insured Person is out of the country for a period of more than 15 days continuously and/or maximum up to 180 days, then this Policy will be extended for the number of days the Insured Person were out of the country.

If the Insured person/s is/are out of the country frequently within a Policy Year, the coverage will be extended for the number of days of the single visit which has maximum/ higher number of overseas days within a Policy Year.

In case of a Family Floater policy, the maximum number of days all Insured/Insured Person/s is/are out of the country for a period of more than 15 days continuously and/or up to 180 numbers of days continuously, together in a single visit shall be considered while extending the Policy tenure.

The Insured Person/s needs to intimate the requirement for extension of Policy tenure to the Company, before the Policy expiry date.

Below covers are available in selective Plans and on payment of additional premium before inception or at Renewal of the Policy subject to the terms, conditions and exclusions applicable

to this Section and the terms, conditions, General exclusions stated in the Policy. The limits applicable to each Optional cover is as mentioned under the specific individual cover.

1. Zero deduct cover

By opting this cover, the list of excluded expenses towards 'Non-medical expenses' as mentioned in the Annexure-A of the Policy, stands waived off. All Reasonable and customary charges of these items will be indemnified as part and up to the Basic Sum Insured.

2. Vector Borne Disease Benefit

We will pay you the lumpsum amount as stated in the Policy Schedule applicable for a single member or for all members insured under a Family Floater policy if You are diagnosed with any of the below listed 'Vector Borne Diseases' and getting treated within the same Policy period. The Sum Insured applicable here is the part of the Basic Sum Insured and applicable for a Policy Year.

3.1 List of Vector Borne Diseases:

I. Dengue Fever,
II. Malaria,
III. Chikungunya
IV. Japanese Encephalitis,
V. Kala-azar,
VI. Lymphatic Filariasis – Payable only once in a lifetime,
VII. Zika Virus

.

Except 'Lymphatic Filariasis' other listed Vector Borne Diseases are payable on a Yearly basis for new occurrence or re-occurrence of any of the listed 'Vector Borne Diseases', whereas 'Lymphatic Filariasis' is payable only once in a lifetime.

3.2 Conditions applicable:

I. **Dengue Fever:**

The diagnosis of Dengue needs to be confirmed by Medical Practitioner along with laboratory examinations results countersigned by a Pathologist/microbiologist indicating –

1. Decreasing platelet levels- less than 100,000 cells/mm3; and

2. Immunoglobulins /Polymerase Chain Reaction (PCR) test showing positive results for Dengue

3. Concurrent to the above two conditions the final diagnosis should be confirmed as Dengue Fever

II. **Malaria**:

The diagnosis of Malaria needs to be confirmed by a medical practitioner with confirmatory tests indicating presence of Plasmodium falciparum/ vivax/ malaria in

his/her blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

III. Chikungunya:

The diagnosis of Chikungunya needs be confirmed by a Medical Practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies

IV. Japanese Encephalitis

The diagnosis needs to be confirmed by a Medical Practitioner by positive serological test for Japanese Encephalitis by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

V. Kala-azar

The diagnosis of Visceral Leishmaniosis, also known as Kala-azar needs to be confirmed by a Medical Practitioner by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for kala azar indicating presence of this disease.

VI. Lymphatic Filariasis – Payable only once in a lifetime

The diagnosis of Filariasis commonly known as elephantiasis, and same must be confirmed by a Medical Practitioner with laboratory examination with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following Clear and visible manifestation of the disease:

1. lymphoedema,
2. elephantiasis and
3. scrotal swelling
4. Concurrent to the above three conditions the final diagnosis should be confirmed as Filariasis

Note-

1. Pre-existing Lymphatic Filariasis at the time of taking the policy is excluded for lifetime
2. Once the Section Sum Insured for the policy year is paid for the Insured Person, no other claim for this condition shall be paid to the Insured Person in his/her entire lifetime.

VII. Zika Virus

The diagnosis needs to be confirmed by a Medical practitioner by plaque-reduction neutralization testing (PRNT). PRNT is performed by CDC or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results.

3.3 Specific Waiting Period applicable

1. **30 days Waiting Period:** Code Excl03 (As mentioned under Part V.3 General Exclusion)
2. **60 days Waiting Period**: Applicable following diagnosis of any listed Vector Borne Diseases

If the Policy is opted after occurrence of any of the listed vector borne diseases, 60 days waiting period shall be applicable for the specific ailment from date of previous admission. However,

a. Single Year Policy - Once a benefit is paid under this section during the Policy Period and the Named Insured Person renews the Policy, in such scenario for the renewal Policy, 60 days waiting period from date of previous date of hospitalization admission would apply for the specific ailment of which a claim has been paid.

b. Multi-Year Policy - Once a benefit is paid under this section during the Policy Year and the policy is continued for the next policy year in case of long-term policy, in such scenario 60 days waiting period from date of previous admission would apply for the specific ailment of which a claim has been paid.

3. **15 days Waiting Period**: If the Policy is renewed post 60 days from the date of admission of the previously paid claim for the named Insured Persons, then a fresh waiting period of 15 days shall apply for all listed Vector borne diseases.

3. Super Booster

The Loyalty Perk (Cumulative Bonus) as available under Part IV.2 (Renewal Features) would get increased by 150% of the Basic Sum Insured within just three claim free Policy year renewals provided that:

a. Your Cumulative Bonus would get increased by 40% of Basic Sum Insured for every claim free year maximum up to 150% of Basic SI. It's with addition to 10% Cumulative Bonus available with your Policy as an in-built feature. By opting this ' Super Booster' Optional feature, you will be entitled to get 50% of Basic Sum Insured as an additional Sum Insured for every single Claim free Policy year renewal , limited to 150% of Basic Sum Insured,

b. The total Cumulative Bonus available under the Policy shall be subject to per Policy Year and maximum up to 150% of Basic Sum Insured as mentioned in the Policy Schedule,

c. The eligibility of this benefit is as per the terms and conditions stated under Part IV.2 (Renewal Features) 'Loyalty Perk/Cumulative Bonus' of the Policy.

4. EMI Protector Benefit

The Company will pay EMI (s) falling due in respect of the Loan (Loan account number as stated in Schedule to this Policy) obtained by the Insured member suffering from below listed Terminal illness/s and/or when is on the end-of-life care treatment, provided fulfilling below Specific Conditions:

1. **Cancer of Specified Severity:**
   A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
   The following are excluded –
   i) All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
   ii) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii) Malignant melanoma that has not caused invasion beyond the epidermis;
iv) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi) Chronic lymphocytic leukemia less than RAI stage 3
vii) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix) All tumors in the presence of HIV infection

2. Alzheimer's Disease:

a. Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes.
b. The Unequivocal diagnosis of Alzheimer 's disease (presenile dementia) before age 60 that has to be confirmed by a specialist Medical Practitioner (Neurologist) and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT Scan, MRI, PET of the brain).
c. The disease must also result in a permanent inability to perform independently three or more Activities of Daily Living or must result in need of supervision and the permanent presence of care staff due to the disease.
d. These conditions must be medically documented for at least 90 days.

The following conditions are however not covered:

i. non-organic diseases such as neurosis and psychiatric Illnesses;
ii. alcohol related brain damage; and
iii. any other type of irreversible organic disorder/dementia.

3. Motor neuron disease (MND):

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

4. End-Stage Lung Failure:

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i) FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii) Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii) Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
iv) Dyspnea at rest.

5. Parkinson's Disease:

The unequivocal diagnosis of idiopathic Parkinson's Disease by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

i) The disease cannot be controlled with medication; and
ii) There are objective signs of progressive deterioration; and
iii) There is an inability of the Life Assured to perform (whether aided or unaided) at least three of the five "Activities of Daily Living" for a continuous period of at least 6 months:

Drug-induced or toxic causes of Parkinsonism are excluded.

6. **Heart Transplant:**
   - The actual undergoing of a transplant of heart that resulted from irreversible end-stage failure of the heart. The undergoing of a heart transplant has to be confirmed by a specialist medical practitioner (Cardiologist).
   - Stem cell Transplants are excluded.

Specific Conditions applicable to the Section (EMI Protector Benefit)

a. In case of multiple loans of the named Insured person, We would consider the sum of all EMI amount payable up to the selected number of EMI's and/or outstanding number of EMI's and/or Actual outstanding Loan amount whichever is lesser. The total amount payable would be limited up to the Sum Insured as specified in the Policy Schedule.
b. Waiting period of 90 days from inception of the Policy will be applicable.
c. The Loan amount disbursed following diagnosis of any of the listed Terminal illnesses or any major illness requiring In-patient hospitalization shall be excluded from the Policy.
d. The Loan account number or EMI's will be considered only if the Loan details are declared before inception of the policy or at renewal.
e. The cover will get ceased once the claim is accepted and paid for remaining Policy Year.
f. The named Insured person for whom the claim has been accepted and paid, the cover will cease to exist for remaining Policy Year as well as renewal of the Policy.
g. The claim will be paid only once in a lifetime for a single Insured Person.
h. Once the Section Sum Insured for the policy year is paid for the Insured Person, no other claim for this condition shall be paid to the Insured Person in his/her entire lifetime
i. You may still renew the Policy with this cover excluding the claimed Insured Person and/or claimed condition.

5. PED Protector

The Waiting period applicable as specified under 'General Exclusions' of the Policy for '**Pre- existing Diseases- Code –Excl01** for 'Diabetes & related complications' and 'Hypertension & related complications will get reduced as mentioned below and will be a part of the Basic Sum Insured as specified in the Policy Schedule

Plan	E-Connect & Basic	Elite	Supreme & Supreme Plus
PED Waiting period (Diabetes & Hypertension)	**NA**	**2 completed Policy Year:** Coverage limited to 30% of Basic Sum Insured or max upto INR 2 Lacs whichever is lesser	**1 completed Policy Year:** Coverage limited to 30% of Basic Sum Insured or max upto INR 2 Lacs whichever is lesser

	NA	**3 completed Policy Years:** Coverage upto Basic Sum Insured	**2 complete Policy Years:** Coverage upto Basic Sum Insured

Specific Conditions applicable to the Section:

a. Entry age: 50 years and below only can opt this Optional cover
b. Coverage under the policy after the expiry of applicable waiting period for 'Diabetes & related complications' and 'Hypertension & related complications is subject to the same being declared at the time of application and accepted by the Insurer. This coverage is mandatory for 2 consecutive years once opted.

6. Global Cover

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

i. The Insured person/s is/are outside India for the purpose other than undergoing medical treatment/procedure
ii. The medical symptoms first originated whilst the Insured Person/s is/are outside India
iii. The treatment is Medically Necessary and has been certified by a Medical Practitioner as an Emergency care which cannot be deferred till the date of Insured Person/s return/s to India.
iv. The intimation of such hospitalization to the Company or our Service Provider is within 24 hours of admission
v. The Emergency Care Medical Expenses incurred during In-patient Hospitalization only shall be covered.
vi. Any payments under this benefit will only be made in India, in Indian Rupees and on reimbursement basis. The payment of any claim will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for payment of the claim under this benefit.
vii. '30-day waiting period**-** Code- Excl03 & **'**Specified disease/procedure waiting period**-** Code- Excl02- First Year Waiting Period**'** as specified under Part V 'General Exclusions' of the Policy shall be waived off under this cover.
viii. We shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.
ix. The cover is available for a maximum period of 180 consecutive days.

7. Domestic Travel Plus

We will indemnity up to twice of Basic Sum Insured for an In-patient hospitalization arising due to an Accidental event of a Common carrier whilst the Insured is travelling as a fare paying passenger in any of the public carriers like Bus, ferry, hovercraft, ship, taxi, train, tram, underground train, commercial helicopter or aircraft provided the accidental event is > 150 kms away from the residential address as mentioned in the Policy Schedule.

Note:

a. Maximum In-Patient Hospitalization would be payable up to 2X of Basic Sum Insured as mentioned in the Policy Schedule summing up the in-built Basic Sum Insured.

b. Pre & Post hospitalization expenses will be covered up to the limits as specified in the Schedule to this Policy.

8. Reload of Sum Insured:

The condition specified under Part II.D.11: Restoration of Sum Insured cover **"The Restored Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an illness/disease for which a claim has been paid in the current policy year under Part II-1 of the Policy."** stands waived off if customer opts for this cover. Rest of the Terms & Conditions will be same as applicable to Restoration of Sum Insured Cover.

9. Co-Pay

Depending on the percentage of Co-pay opted, each and every claim under the Policy shall be subject to a Copayment of 5%, 10% or 20% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the copayment.

10. Modern Surgeries limit

The following procedures will be covered (wherever medically indicated) either as in patient or as part of domiciliary hospitalization or as day care treatment in a hospital upto 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. BronchicalThermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM - (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

11. Room Rent limit

i. The Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home will be capped to 1% of the sum insured or maximum up to INR.5000/-, per day whichever is lower.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses will be capped to 2% of the sum insured or maximum up to INR 7,500/- per day whichever is lower.

In case of admission to a Room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

12. Cataract Capping

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit mentioned below, per each eye in one policy year.

Basic Sum Insured	Cataract per eye limit
3 Lakhs to 4 Lakhs	INR 25,000/- per person
5Lakhs to 7.5Lakhs	INR 35,000/- per person
10 Lakhs & Above	INR 40,000/- per person

Age Limit: 50 years of age and above can opt this Optional cover.

Part IV: Renewal Features

1. **Renewal Health Check-up**

   The Insured Person/s above18 years of age is/are entitled to a health check-up, on Cashless basis, at a diagnostic center specified by the Company after a block of every 2 years of continuous yearly Policy renewal with Us irrespective of the claims made under the Policy in E-Connect, Basic, Elite & Supreme plan and after every policy year, irrespective of the claims made under the Policy in Supreme Plus plan subject to continuation of Policy with Us. This is available for the Insured Person/s who were insured with Us for the above specified period.

Sum Insured (in Lakhs)	List of Investigations
2,3,4	Complete blood Count, Routine Urine Analysis, Blood group, ESR, Fasting Blood Sugar, Sr. Cholesterol, SGPT, Creatinine, ECG
5 and above	Complete blood Count, Routine Urine Analysis, Blood group, ESR, Fasting Blood Sugar, Lipid profile, Kidney Function Test, Medical Examination Report

2. The Insured Person who do not make claim, will be rewarded with any one of the below two options as per the choice/ express consent of the Insured Person at the time of every renewal:
   a. Loyalty Perk (Cumulative Bonus)

   This Policy provides for auto increase in Basic Sum Insured by 10% on the Basic Sum Insured for every claim free Policy year up to a maximum of 100% of the Basic Sum Insured

   a. For a Family Floater policy, the loyalty perk shall be available only on floater basis and shall accrue only if no claim has been made in respect of any Insured Person during the expiring Policy Year. The loyalty perk which is accrued during the claim free Policy Year will only be available to those Insured Persons who were insured in such claim free Policy Year and continue to be insured in the subsequent Policy Year.
   b. If the Insured Person/s in the expiring Policy are covered on a Floater Basis and the Policy renewal for such Insured Person/s is done by splitting the floater Sum Insured into 2 or more floater / individual covers, then the Loyalty Perk of the expiring Policy shall be apportioned to such renewed Policy/ies in proportion to the Sum Insured under each of the renewed Policy/ies.
   c. If the Insured Person/s in the expiring Policy are covered on an Individual basis and thereby enjoy separate Loyalty Perk in the expiring Policy/ies, and such expiring Policy/ies is renewed with the Company on a Floater Basis, then the Loyalty Perk carried forward under such renewed floater Policy would be the least of the Loyalty Perk/s earned under the expiring Policy/ies..

d. Entire loyalty perk will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace period whichever is later.
e. Where a portion of/ full Loyalty Perk earned is utilized following a claim, the balance if any available will be carried forward for the immediate renewal. However, the Policy would not qualify for any fresh Loyalty Perk on the immediate Policy renewal.

b. Discount in Renewal Premium

Insured has choice to choose Discount in renewal premium in the in lieu of auto increase in Basic Sum Insured (Loyalty Perk /Cumulative Bonus) for every claim free Policy year

3. Basic Sum Insured Enhancement

Basic Sum Insured can be enhanced 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 by the Company. In all such case of increase in the Basic Sum Insured, waiting period will apply afresh in relation to the amount by which the Basic Sum Insured has been enhanced.

Part V: General Exclusions

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	First Year (12 months) Waiting Period	Two Year (24 months) Waiting Period	Three Year (36 months) Waiting Period
1.	Cataract	Calculus diseases of Gall bladder and Urogenital system	Surgical treatment of Obesity
2.	Benign Prostatic Hypertrophy	Joint Replacement due to Degenerative condition,	
3.	Hernia	Surgery for prolapsed inter vertebral disc unless arising from accident	
4.	Hydrocele	Age related Osteoarthritis and Osteoporosis	
5.	Fistula in anus	Spondylosis / Spondylitis	
6.	Piles	Surgery of varicose veins and varicose ulcers.	
7.	Sinusitis and related disorders	Treatment for correction of eyesight (laser surgery) due to refractive error	
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,mastoid ectomy, tonsillectomy and tympanoplasty		
16.	Dilatation and		

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

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

7. **Change-of-Gender treatments: Code- Excl07**
   Expenses related to any treatment, including surgical management, to change characteristics

of the body to those of the opposite sex.

8. **Cosmetic or plastic Surgery: Code- Excl08**
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner
9. **Hazardous or Adventure sports: Code- Excl09**
   Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

10. **Breach of law: Code- Excl 10**
    Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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

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

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

14. Dietary supplements and substances that can be purchased without prescription including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code-Excl 14**

15. Refractive error: **Code – Excl15**
    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 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. **Sterility and Infertility: Code- Excl17**
    Expenses related to sterility and infertility. This includes:
    (i) Any type of contraception, sterilization
    (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

18. **Maternity: Code Excl18**

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

iii. 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 unless specifically mentioned in your policy schedule.

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:
    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.

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

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

F. GENERAL TERMS AND CLAUSES

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

1. Disclosure of information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
("Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. 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.

3. 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 falls due

4. Complete Discharge

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

5. 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.

6. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if 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.

7. 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.

c. In case of Installment policy, Policy will be cancelled with proportionate premium refund for unexpired policy period if there is no claim made during the policy period.

(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.

Cancellation Grid	Time period	Claim Status	One Year - Single payment /Instalment policy	2/3 Years Policy tenure -Single payment /Instalment policy
Free Look Period (Risk not commenced)	Upto30 days	Nil	Full refund less medical examination of insured person and the stamp duty charges	

Free Look Period (Risk commenced)	Upto30 days	Nil	Proportionate refund for unexpired policy period
Pro rate (Risk commenced)	Beyond 30 days	Nil	Proportionate refund for unexpired policy period

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

8. Migration:

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

9. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with 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 Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

10. 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 give notice for renewal atleast 30 days prior to expiry of the policy.
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.

11. Withdrawal of Policy

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

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

12. 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.

13. Premium Payment in Installment:

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly or any other specific frequency as mentioned in the policy Schedule/Certificate of Insurance the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

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.

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

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

vii. 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%

14. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

15. 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

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

16. 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 **Write to us at:** **Customer Service** **Liberty General Insurance Limited** Unit 1501&1502, 15th Floor, Tower 2, One International Center, Senapati Bapat Marg, Prabhadevi, Mumbai – 400013	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

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 as per the Insurance Ombudsman Rules 2021. 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/

17. Nomination

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

ii. 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 anyone (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**

It is a Condition Precedent to the Company's liability under the Policy that the Insured Person/s shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his/ their own expense. The Company may, in its discretion, adjust the scope of cover and/or the premium paid or payable, accordingly.

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 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. Notice

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

10. 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.

G. OTHER TERMS AND CONDITIONS:

1. Entry Age

Minimum entry Age: Adult –18 years; Dependent Child -91 days
Maximum entry Age: 65 Years

2. **Dependent child/children**

Dependent child/children covered with Us under Family Floater shall have the option to continue renewal by migrating to a suitable policy at the end of the specified exit 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. Referral Risk

Proposals where the Health status is adverse, as revealed in the proposal form or as evidenced in the pre policy 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 Basic Sum Insured. In all such cases, we would send a communication letter to the Proposer and obtain his/her consent before acceptance of the Proposal.

4. Discount Parameters

i. Family Discount: A Family discount of 10% will be given if more than 2 family members are covered on Individual Sum Insured basis
ii. 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.
iii. Employee Discount: 10% discount if the client is an employee of the Company

iv. Direct Policy Purchase Discount- 10% discount will be given if you are purchasing this Policy through Our Website.
v. Complete Insurance Package Discount: Avail discount of 1% per active policy maximum up to 4%, with Liberty's Motor Insurance Policy, Critical Connect policy, Individual Personal Accident Policy & Health Connect Supra Policy.
vi. Discount for Female proposer: Avail discount of 5% for Female proposer.

5. Claim Procedure:

a. **Notification of claim:** Upon the happening of any event giving rise or likely to give rise to a claim under this Policy, the Insured Person/s shall give immediate notice to the TPA named in the Policy/Health Card or the Company by calling toll-free number as specified in the Policy/Health Card or in writing to the address shown in the Schedule with Particulars below:
   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 atleast 48 hours prior to planned hospitalization and within 24 hours of hospitalization in case of emergency hospitalization. In event of any claim for Pre – Post Hospitalization expenses incurred, all claim related documents needs to be submitted within 7 days from the date of completion of treatment or eligible Post Hospitalization period as mentioned in the policy schedule whichever is earlier.
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 thirty working days of receipt of the last required documents.

b. For opting 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 no and Policy Number and take an eligibility number to confirm communication. The same has to be quoted in the claim form. The call must be made 48 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 24 hours of admission.

   i. The company may provide Cashless facility for Hospitalisation expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorisation letter to the health care service provider.
   ii. For the purpose of considering Pre-Authorisation and Cashless facility, the Insured Person/s shall submit to the TPA complete information of the disease, requiring treatment along with necessary certification from the Hospital/Medical Practitioner.
   iii. If the claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorisation to the Hospital concerned for cashless facility whereby hospitalization expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorisation.

iv. Cashless facility will not be available in Non-network Hospital and may be declined even for treatment at a network hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such cases, the Insured Person/s shall bear such expenses and claim reimbursement immediately after discharge from the Hospital.
v. The list of Network hospitals where we are having cash less arrangement would be made available to the Policy holder and subsequent amendments to the same would also be duly communicated by us/ the TPA service provider.

c. **Reimbursement Claims** - 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 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
ix. Any additional documents or information, as may be deemed necessary by the Company or TPA.

The Insured Person/s shall at any time as may be required authorize and permit the TPA and/or Company / or its associated representative 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 Basic 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.

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

➢ **In-patient Treatment /Day Care Procedures**

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

➢ **Road Traffic Accident**

In addition to the In-patient Treatment documents:

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

In Non Medico legal cases

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

In Accidental Death cases

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

➢ **For Death Cases**

In addition to the In-patient Treatment documents:

- ❑ Original Death Summary from the hospital.
- ❑ Copy of the Death certificate from treating doctor or the hospital authority.
- ❑ Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

➢ **Pre and Post-hospitalisation expenses**

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

- **Ambulance Benefit**
- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ Original Bill with Original Payment Receipt.
- ❑ Treating Doctor's consultation prescription indicating Emergency Hospitalization.

- **Reimbursement of Organ Donor Expenses**

In addition to the documents of general hospitalization

- ❑ Organ Function test / blood test proving organ failure.
- ❑ Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

- **Hospital Cash Allowance**

Same as In-patient Hospitalisation treatment

- **Restoration of Basic Sum Insured**

Same as In-patient Hospitalisation treatment

- **Recovery Benefit**

Same as In-patient Hospitalisation treatment

- **Nursing Allowance**

In addition to the In-patient Treatment documents:

- ❑ Duly signed prescription for Private Nursing requirement and its necessity from the treating Medical Practitioner
- ❑ Nurse Qualifications: ANM/GNM degree from a recognized institution in India and Valid nursing license issued by The Indian Nursing Council
- ❑ Original Bill with Original Payment Receipt of Nursing charges from the utilized Nursing Burrow/Private Nurse

- **Extended Policy Tenure**
- ❑ Proof of travel outside the Country specifying a period more than 15 days consecutively.

- **AYUSH Treatment**

Same as In-patient Hospitalisation treatment

- **Vector Borne Disease Benefit**
- ❑ Duly filled and signed Claim Form.
- ❑ Photocopy of ID card / Photocopy of current year policy.
- ❑ First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from attending Medical Practitioner demanding such test.
- ❑ Attending Doctors/ Consultants/ Specialist's Bill and receipt and certificate regarding same
- ❑ Original medicine bills and receipts with corresponding Prescriptions.
- ❑ Doctors registration Number and Qualification from the doctor

- **EMI Protector Benefit**
- ❑ Submission of sanction letter from the Financial Institute or Bank from where loan is applied
- ❑ Repayment track record from the Financial Institute or Bank
- ❑ Bank account statement reflecting EMI for the loan
- ❑ Loan account statement

- ❑ A medical certificate confirming the diagnosis of Terminal illness from a specialist doctor as mentioned under each Terminal illness.
- ❑ Medical certificate for the duration of Terminal illness.
- ❑ An Investigation reports / other related documents reflecting the Terminal illness diagnosis

➢ **Global Cover**
Same as In-patient Hospitalisation treatment

➢ **Domestic Travel Plus**
Same as In-patient Hospitalisation treatment

➢ **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. We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions or reject the claim as per the Policy terms and conditions within 30 days of submission of all necessary documents / information and any other additional information required for the settlement of the claim. However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.
f. All claims will be settledas per relevant provisions of applicable Circulars and Regulations issued by IRDAI from time to time. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed underrelevant provisions of applicable Circulars and Regulations issued by IRDAI from time to time , we shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us For the purpose of this clause, 'bank rate' means **"**Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due"
g. No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy

Benefit Schedule* – *As Annexed

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:

Microsurgical operations on the middle ear

1. Stapedotomy
2. Stapedectomy
3. Revision of a stapedectomy
4. Other operations on the auditory ossicles
5. Myringoplasty (Type -I Tympanoplasty)
6. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
7. Revision of a tympanoplasty
8. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) of the inner ear
18. Other operations on the middle and inner ear

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration

Operations on the eyes

23. Incision of tear glands
24. Other operations on the tear ducts
25. Incision of diseased eyelids
26. Excision and destruction of diseased tissue of the eyelid
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea

32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye
36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract

Operations on the skin & subcutaneous tissues

39. Incision of a pilonidal sinus
40. Other incisions of the skin and subcutaneous tissues
41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42. Local excision of diseased tissue of the skin and subcutaneous tissues
43. Other excisions of the skin and subcutaneous tissues
44. Simple restoration of surface continuity of the skin and subcutaneous tissues
45. Free skin transplantation, donor site
46. Free skin transplantation, recipient site
47. Revision of skin plasty
48. Other restoration and reconstruction of the skin and subcutaneous tissues
49. Chemosurgery to the skin
50. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

51. Incision, excision and destruction of diseased tissue of the tongue
52. Partial glossectomy
53. Glossectomy
54. Reconstruction of the tongue
55. Other operations on the tongue

Operations on the salivary glands & salivary ducts

56. Incision and lancing of a salivary gland and a salivary duct
57. Excision of diseased tissue of a salivary gland and a salivary duct
58. Resection of a salivary gland
59. Reconstruction of a salivary gland and a salivary duct
60. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

61. External incision and drainage in the region of the mouth, jaw and face
62. Incision of the hard and soft palate
63. Excision and destruction of diseased hard and soft palate
64. Incision, excision and destruction in the mouth
65. Plastic surgery to the floor of the mouth
66. Palatoplasty
67. Other operations in the mouth

Operations on the tonsils & adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy
71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids

Trauma surgery and orthopaedics

73. Incision on bone, septic and aseptic
74. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
75. Suture and other operations on tendons and tendon sheath
76. Reduction of dislocation under GA
77. Arthroscopic knee aspiration

Operations on the breast

78. Incision of the breast
79. Operations on the nipple

Operations on the digestive tract

80. Incision and excision of tissue in the perianal region
81. Surgical treatment of anal fistulas
82. Surgical treatment of haemorrhoids
83. Division of the anal sphincter (sphincterotomy)
84. Other operations on the anus
85. Ultrasound guided aspirations
86. Sclerotherapy etc.

Operations on the female sexual organs

87. Incision of the ovary
88. Insufflation of the Fallopian tubes
89. Other operations on the Fallopian tube
90. Dilatation of the cervical canal
91. Conisation of the uterine cervix
92. Other operations on the uterine cervix
93. Incision of the uterus (hysterotomy)
94. Therapeutic curettage
95. Culdotomy
96. Incision of the vagina
97. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
98. Incision of the vulva
99. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

100. Incision of the prostate
101. Transurethral excision and destruction of prostate tissue
102. Transurethral and percutaneous destruction of prostate tissue
103. Open surgical excision and destruction of prostate tissue
104. Radical prostatovesiculectomy
105. Other excision and destruction of prostate tissue
106. Operations on the seminal vesicles
107. Incision and excision of periprostatic tissue
108. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

109. Incision of the scrotum and tunica vaginalis testis
110. Operation on a testicular hydrocele
111. Excision and destruction of diseased scrotal tissue
112. Plastic reconstruction of the scrotum and tunica vaginalis testis
113. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

114. Incision of the testes
115. Excision and destruction of diseased tissue of the testes
116. Unilateral orchidectomy
117. Bilateral orchidectomy
118. Orchidopexy
119. Abdominal exploration in cryptorchidism
120. Surgical repositioning of an abdominal testis
121. Reconstruction of the testis
122. Implantation, exchange and removal of a testicular prosthesis
123. Other operations on the testis

Operations on the spermatic cord, epididymis and ductus deferens

124. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
125. Excision in the area of the epididymis
126. Epididymectomy
127. Reconstruction of the spermatic cord
128. Reconstruction of the ductus deferens and epididymis
129. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

130. Operations on the foreskin
131. Local excision and destruction of diseased tissue of the penis
132. Amputation of the penis
133. Plastic reconstruction of the penis
134. Other operations on the penis

Operations on the urinary system

135.Cystoscopical removal of stones

Other Operations

136. Lithotripsy
137. Coronary angiography
138. Haemodialysis
139. Radiotherapy for Cancer
140. Cancer Chemotherapy

Note: The standard exclusions and waiting periods are applicable to all of the above Day Care Procedures depending on the medical condition/ disease under treatment. Only 24 hours hospitalization is not mandatory.

Annexure-A

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

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES

21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
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 (*Payable incase medically advisable for the treatment)
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

Liberty General Insurance Limited
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

Grievance Redressal

Annexure - B

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

Step 1

Call us on Toll free number: **1800-266-5844**
(8:00 AM to 8.00 PM, 7 days of the week)
or
Email us at: care@libertyinsurance.in
or
Write to us at:
Customer Service
Liberty General Insurance Limited
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013

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**

An acknowledgment will be sent on receipt of your concern, we would then investigate the matter internally and respond with a suitable resolution. Please share your contact details to enable us to get in touch with you.

In case you are not satisfied with the decision or resolution provided by the company you may approach the Insurance Ombudsman for redressal. The details of Insurance Ombudsman Offices are given below:

Office of the Ombudsman and Contact Details	Areas of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02 Email: oio.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,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: oio.bengaluru@cioins.co.in	Karnataka
BHOPAL Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Area Hills, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: oio.bhopal@cioins.co.in	Madhya Pradesh and Chattisgarh
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar - 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: oio.bhubaneswar@cioins.co.in	Orissa
CHANDIGARH Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector - 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: oio.chandigarh@cioins.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI - 600 018. Tel.: 044 - 24333668 / 24333678 Email: oio.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: oio.delhi@cioins.co.in	Delhi
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 – 2358759 Email: oio.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: oio.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

Office of the Ombudsman and Contact Details	Areas of Jurisdiction
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: oio.hyderabad@cioins.co.in"	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: oio.jaipur@cioins.co.in	Rajasthan
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: oio.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: oio.lucknow@cioins.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.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: oio.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar,U.P - 201301. Tel.: 0120-2514252 / 2514253 Email: oio.noida@cioins.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.

Insurance is the subject matter of the solicitation.
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Liberty General Insurance Limited
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

Office of the Ombudsman and Contact Details	Areas of Jurisdiction
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: oio.patna@cioins.co.in	Bihar, Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020-24471175 Email: oio.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region
THANE Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg,Thane (West)- 400604 Tel.: 022-20812868/69 Email: oio.thane@cioins.co.in	Maharashtra

GOVERNING BODY OF INSURANCE COUNCIL,
Shri P.N.Gandhi, Secretary General
Smt Moushumi Mukherji, Secretary
3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.
Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949
Email: inscoun@cioins.co.in

For the latest details of Ombudsman offices, please visit the Insurance Ombudsman website at the following link: https://www.cioins.co.in/Ombudsman

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