Liberty General Insurance Ltd.
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013,
Phone: +91 226700 1313 Fax: +91 226700 1606
Toll Free : 1800 266 5844
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656
Website Link: www.libertyinsurance.in

Liberty Eternia Health 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.

2. **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

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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.

3. **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.

4. **"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.

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

6. **"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.

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7. **"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.

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

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

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

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

11. **"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.

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

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

14. **"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,

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

15. "**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.

16. **"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.

17. **"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.

18. **"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.

19. **"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

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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

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

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

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

23. **"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.

24. **"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.

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

26. **"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.

27. **"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.

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

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

30. **"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.

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

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

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

34. **"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

35. **"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.

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

37. **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 hospitalization was required, and

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ii. The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.

38. **"Portability"** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc from the Existing Insurer in the previous policy to the Acquiring Insurer

39. **"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.

40. **"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.

41. **"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.

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

43. **"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.

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

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.

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i. **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 Inpatient hospitalisation 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

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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, live-in partner,child/children, parents/ parent-in-laws,siblings 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. "**Green Channel Hospitals**" means set of select hospitals or health care providers enlisted by Liberty General Insurance Limited, TPA or jointly by an Liberty General Insurance Limited and TPA under Green Channel section on the company's website.

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

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

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

17. **"Policy"** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

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18. **"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.

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

20. **"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.

21. **"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.

22. **"Single Private Room"** means an air-conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital**.**

23. **"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.

24. "**Twin Sharing Room**" means an air conditioned Hospital room where at least two patients are accommodated at the same time. Such room shall be the most basic and the most economical of all accommodations available as twin sharing rooms in that Hospital

25. **"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.

26. **"Waiting Period"** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period,

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diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

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

28. **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 reasonable and customary charges 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 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', 'Super Booster' and 'Domestic Travel Plus' unless opted for Unlimited Claim Optional Cover 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. other than those specified in the list of excluded expenses (non-medical) in Annexure A
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

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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.

c. 2 Hour Hospitalisation

We will cover the following Medical Expenses incurred in respect of Hospitalization of the Insured Person for 2 hours or more (minimum 24 hours for AYUSH treatment in a AYUSH Hospital) for emergency care during the Policy Period, up to the Annual Sum Insured specified in the Policy Schedule:

i. Room Rent charges up to Single Private AC room;
ii. Intensive Care Unit Charges;
iii. Qualified Nurse charges;
iv. Medical Practitioner's Fees;
v. Anesthesia, blood, oxygen, operation theatre charges, medicines, drugs and consumables (other than those specified in the list of excluded expenses (non-medical) in Annexure II.
vi. Surgical appliances and prosthetic devices recommended in writing by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure. Cost of investigative tests or prescribed diagnostic procedures directly related to the Injury/Illness for which the Insured Person is hospitalized

Expenses associated with automation machine for peritoneal dialysis shall not be payable
We will NOT pay, even if you were hospitalized, if there was no active line of treatment and only investigations were done. Examples: MRI, CT Scan, Endoscopy, Colonoscopy etc.
Treatments or procedures covered under this benefit and "Day care procedures/ Treatment" are separate.

2. 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;

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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
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.

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

3. 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.

4. 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.

5. Domiciliary Hospitalisation Treatment

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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.

6. Hospital Daily Cash Allowance

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

7. 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.

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iv) Any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence while transferring an Insured Person after he/she has been discharged from the Hospital are not payable under this Benefit.

8. 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 cover only those Medical Expenses incurred in respect of an organ donor as an in-patient in the Hospital.
iii. We have accepted a claim under Section "Inpatient treatment" in respect of the Insured Person.
iv. We shall not be liable to pay for any claim under this Cover which arises for or in connection with any of the following:

- Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
- Screening expenses of the organ donor.
- Any other Medical Expenses as a result of the harvesting from the organ donor.
- Costs directly or indirectly associated with the acquisition of the donor's organ.
- Transplant of any organ/tissue where the transplant is experimental or investigational.
- Expenses related to organ transportation or preservation.
- Expenses incurred by an Insured Person as a donor.
- Any other medical treatment or complication in respect of the donor, consequent to harvesting. A valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

9. 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

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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

10. 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.

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:

i. This benefit will be triggered unlimited times for any illness/disease/injury.
ii. The total amount of restoration will not exceed the Annual Basic Sum Insured for that Policy Year
iii. This benefit will not be available for Policies with Unlimited Claim option.
iv. The Annual Sum Insured including Cumulative Bonus, (if opted and accrued), Super Booster (if opted and accrued) in respect of the Insured Person is insufficient as a result of previous claims paid in that Policy Year.
v. This Benefit will not be triggered for the first claim made during the Policy Year
vi. This Benefit will be applied only if the claim is made and admissible under “Inpatient Treatment” or “Daycare Procedure/Treatment” or “In-patient AYUSH Hospitalization”
vii. For individual policies, reset amount will be available on individual basis whereas for floater policies, it will be available on floater basis.
viii. The Benefit will not be available for an Illness /Injury or related complications including but not limited to any relapse within 45 days in respect of which a claim has been paid in that Policy Year for the same Insured Person
ix. Any unutilized Restored Sum Insured will not be carried forward to any subsequent Policy Years.
x. Restored Benefit will not be triggered for claims, treatment, expenses incurred outside the geographical limits of India.

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xi. 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.

12. 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.

The benefit under this cover will not be extended in event of a valid claim under **Global Cover for Emergency Hospitalization.**

13. Wellness Program

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

1. **First Medical Opinion :**

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

i. First Medical Opinion service provides an unbiased opinion on simple medical queries that have not been taken to a medical expert as of yet.
ii. This benefit can be availed only once during the Policy Year by each Insured Person covered on Individual or Family Floater policy.

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

2. **Live Health Talk :**

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

3. **Electronic Medical Record Management (EMRM**) :

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

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4. **Fortnightly Newsletters :**

Relevant and Crisp Fortnightly Publication on Health & Lifestyle Awareness would be available for you on the Portal.

Health 360°

The Company covers below listed benefits to ensure the Insured person/s Health & Wellness under this Policy by offering services & incentivizing rewards as mentioned below.

A. Delight Healthcare :

The Insured Person/s can avail discounts on outpatient consultation, pharmaceuticals and Diagnostic tests through our empanelled Network Providers. The list of such Network Providers will be updated from time to time and can be obtained from our website, mobile application or by calling our call centre. We will assist in scheduling appointments for consultation and diagnostic tests at a time convenient to the Insured Person. Alternatively, the Insured Person may also schedule his/her own appointment by contacting the Network Provider or through the mobile application.

The Insured Person/s can avail these facilities as many times as wishes to avail. In all cases, the medical professional suggested by the Company shall act in a medical or legal

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capacity on behalf of You only. The Company assumes no responsibility for any medical advice given by the medical professional. You shall not have any recourse to the Company by reason of its suggestion of a medical professional or due to any legal or other determination resulting therefrom. The services are on an arrangement basis and utilising these services from the Company's empanelled network provider would be at the discretion of the Insured member. You are responsible for the cost of services arranged by the Company on behalf of You or a covered Immediate Family member.

1. **OPD consultation :**
   The Company arranges family physician as well as specialist consultations at discounted rates from the Network Providers. The Insured Person/s can also store the prescription letters and bills in the electronic health portal system

2. **Diagnostic services :**
   The Company arranges diagnostic facilities at discounted rates from the Network Providers. The insured person can avail this facility as many number of times as the person wishes to avail. The insured person can also store these medical test reports and bills in the electronic Health portal system.

3. **Pharmacies :**
   If the Insured Person/s wants to obtain medicines and consumables prescribed by a Medical practitioners, he/she can avail home delivery facilities through our web portal or mobile application. These medicines and consumables are available at discounted rates subject to a valid prescription.

14. Cumulative Bonus :

We will provide a Cumulative Bonus as per the plan opted over the expiring or renewed Annual Sum Insured (whichever is lower) at the end of each Policy Year irrespective of a claim being initiated in the Policy Year, provided that the Policy has been continuously renewed with the Company. The Cumulative Bonus will not be accumulated for more than the limit specified in the opted plan as per the plan opted of the Annual Sum Insured under any circumstances subject to the following conditions: -

i. The Cumulative Bonus accumulated will be on floater basis for a floater Policy and on individual basis for an individual Policy.
ii. In a floater Policy as specified in the Policy Schedule, the Cumulative Bonus so accrued in the previous Policy Year(s), will only be available to those Insured Person(s) who were Insured in the previous Policy Year(s) and continue to be Insured with the Company in the subsequent Policy Year(s).

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iii. Cumulative Bonus will not be added if the Policy is not renewed with the Company by the end of the Grace Period.
iv. Cumulative Bonus can only be utilized when the Annual Sum Insured is completely exhausted.
v. If the Policy Period is two or three year(s), any Cumulative Bonus that has accrued for first/second Policy Year will be credited at the end of first/ second Policy Year, as per the Policy Period, and it will be available for claims at the subsequent year.
vi. If the Insured Persons in the expiring Policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been renewed with the Company on a floater basis as specified in the Policy Schedule then the Cumulative Bonus to be carried forward for credit in such renewed Policy shall be the lowest among all the Insured Persons.
vii. In case of floater Policies where Insured Person renew their expiring Policy with the Company by splitting the Annual Sum Insured in to individual policies the Cumulative Bonus of the expiring policy shall be apportioned to such renewed policies in the proportion of the Annual Sum Insured of each renewed Policy.

15. Bariatric surgery per policy period :

We will cover medical expenses incurred in respect of Hospitalization of the Insured Person for Surgical Procedure/treatment for Obesity up to Annual Sum Insured, subject to below conditions and Eligibility criteria:

i. The surgery has to be conducted upon the advice of a Medical Practitioner.
ii. The surgery/procedure conducted should be supported by clinical protocols.
iii. The Insured Person undergoing the bariatric surgery/procedure has to be 18 years of age or older.
iv. Body Mass Index (BMI) of the insured person has to be
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:
    a. Obesity-related cardiomyopathy
    b. Coronary heart disease
    c. Severe Sleep Apnea
    d. Uncontrolled Type2 Diabetes

Conditions :

i. Any kind of Additional Sum Insured accrued as a part of Cumulative Bonus /Super Booster / Restoration of Basic Sum Insured benefit will not be available for this cover.
ii. The Insured Person shall mandatorily obtain cashless approval prior to undergoing the surgery/ treatment.
iii. Bariatric surgery/treatment performed for cosmetic reasons is excluded.

16. Technological Advancements (Modern Surgeries) :

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We will cover the Medical Expenses incurred in respect of Hospitalization of the Insured Person for the below mentioned Technological Advancements and Treatments during the Policy Period, up to the Annual Sum Insured.

Sr No.	Treatment/Procedure
1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
2	Immunotherapy- Monoclonal Antibody to be given as injection
3	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
4	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
5	Balloon Sinuplasty
6	Oral Chemotherapy
7	Robotic surgeries
8	Stereotactic radio Surgeries
9	Deep Brain stimulation
10	Intra vitreal injections
11	Bronchial Thermoplasty
12	IONM - (Intra Operative Neuro Monitoring)

17. Accidental Sum Insured :

In event of Death on account of an accident/ Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period.
We will pay you the lumpsum amount as stated in the Policy Schedule applicable. This cover is available only for adult members aged maximum up to 60 years during first time issuance.

18. Sub Limits on Medical Expenses:

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

19. Compulsory Co-Payment :

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

This cover will be available as per the plan opted and specified in the policy schedule.

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20. Zero deduct cover :

This benefit will indemnify the Reasonable and customary charges of excluded expenses towards 'Non-medical expenses' as mentioned in the Annexure-A of the Policy, subject to a valid claim being admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

i. Claims under this add on/Optional Cover shall be limited to treatment taken within the geographical boundaries of India. Hence, this cover is not applicable to Optional Cover -Global Cover in case of Emergency Hospitalization.
ii. Any Sum Insured accrued under Cumulative Bonus / Restoration of Basic Sum Insured /Super Booster option cover(if opted) / will not be available for Zero Deduct Cover.
iii. This cover may be opted out at the time of renewal if available and specified in the policy schedule.
iv. This cover will be available as per the plan opted and specified in the policy schedule.
v. The Sum Insured for this Cover shall be subject to overall limit of the Basic Sum Insured.

21. Specific disease waiting period Reduction :

This Cover will be provided only if You have opted and paid additional premium or is specified in the policy schedule as per the selected plan.

The waiting period applicable under Exclusion- Specified disease/procedure waiting period (Code- Excl02) shall be reduced from 24 months to 12 months.

This cover will be available only during inception of the policy and only for the Annual Sum Insured chosen at the time of Policy Inception.

The reduced waiting period shall not be applicable for claims made under Optional Cover - Global Cover.

Once chosen, this optional cover will have to be opted for a period of 2 continuous policy years.

22. Maternity Cover :

This Cover will be provided only if You have opted for the Maternity Cover by payment of additional premium or as specified in the policy schedule as per the selected plan.

The Sum Insured opted under this cover is applicable up to the limits as stated in the Policy Schedule.

The Company will indemnify the Reasonable & customary Medical expenses for the delivery of a baby (including caesarean section) and/or expenses related to medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the insured person, provided that,

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i. Our maximum liability per delivery or termination shall be limited to the amount specified in the policy Schedule as per the plan opted
ii. We will pay the Medical Expenses of pre-natal (period from conception until delivery of baby) and post-natal hospitalization (up to 30 days from date of delivery of baby) per delivery or termination upto the amount stated in the policy Schedule within the available maternity Sum Insured.
iii. Waiting period of twenty four **(24) months** from the time this cover is opted, provided that the policy has been renewed continuously with us without break for you and/or your spouse insuring under this cover.
iv. Any complications arising out of or as a consequence of maternity/child birth will be covered within the limit of Sum Insured available under this benefit.
v. Medical expenses for Ectopic Pregnancy are not covered under this benefit. However, these expenses are covered under Part D 1. A. (In-patient Treatment Expenses)
vi. This Cover is available for You and/or Your legally married spouse, provided the female Insured person is between age 18 to 50 years as selected by proposer.
vii. In case, Insured Person has already taken a policy without maternity benefit and would like to opt for maternity benefit, then this can be availed only at the time of renewal
viii. Maternity Benefit shall not be available outside the geographical boundaries of India.

23. Newborn Day One Cover :

We will cover the Medical Expenses incurred by the Insured Person on Hospitalization of a "New born Baby" from day one of birth during each Policy Year of Policy Period subject to the maximum limit upto the maternity sum Insured. This limit is over and above the maternity sum insured however within the base sum insured.

i. This Cover will be provided only if You have opted for the Maternity Cover and paid additional premium or as specified in the policy schedule as per the selected plan and We have accepted a claim under Maternity cover under this policy
ii. This benefit will cover Medical Expenses incurred on the "New born Baby" during Hospitalization (for a minimum period of consecutive 24 hours) for a maximum period up to 90 days from the date of birth of the baby.
iii. New born day one cover benefit shall not be available outside the geographical boundaries of India.

Part III: Optional Covers

Below covers are available in selective Plans and on payment of additional premium before inception or at Renewal wherever applicable of the Policy subject to the terms, conditions and exclusions applicable to this Section. The limits applicable to each Optional cover is as mentioned under the specific individual cover or as specified in the policy schedule.

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

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benefit. However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the sum of Basic Sum Insured, Cumulative Bonus, , Restoration of Sum Insured, 'Accidental Sum Insured', and Super Booster and 'Domestic Travel Plus ',' unless opted for Unlimited Claim Optional Cover and specific limits as available to the Insured Person/s and stated in the Policy Schedule. These covers shall not be available outside the geographical boundaries of India except for Global Cover.

The Sum Insured for each of the Optional Covers (except Optional cover - Vector Borne Disease Benefit , Optional Cover - EMI Protector Benefit, Optional Cover - Global Cover for Emergency Hospitalization, Optional cover – PED Protector, Optional Cover - Cataract Capping Discount, Optional Cover- Compassionate Visit, Optional Cover - Nursing at Home) shall be over and above the Annual Sum Insured of the Policy

The benefit under optional covers – Unlimited Claim , PED Protector, EMI Protector Benefit, Global Cover for Emergency Hospitalization , and Nursing at Home will be available only during inception of the policy unless specified in the respective section.

The benefit under optional covers - PED Protector, Super Booster, Voluntary Co-Pay, Voluntary Deductibles, Cataract Capping and cannot be opted out once opted into the policy.

1. **Cataract Capping Discount:**

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

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

2. **Compassionate Travel :**

In event of claim being admissible under Part II 1.a (In-patient Treatment Expenses), which in the opinion of the Medical Practitioner attending on You, extends beyond a period of 10 consecutive days, We will indemnify the cost of the economy class air ticket/railway ticket as mentioned in the policy schedule and incurred by Your Immediate Family Member from and to the place of origin of such Family Member or the place of residence of the Family Member.

Our liability under this Optional Cover, however, in respect of any one event or all events of Hospitalization during the Policy Year shall not in aggregate exceed as specified in the policy schedule per policy year of policy period.

For the purpose of this extension, the term "Immediate Family member" would mean the Insured's Spouse, Children, Parents, and Parents-in-law.

3. **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

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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.

4. Emergency Domestic Medical Evacuation :

We will cover the expenses incurred on Air Ambulance services up to the Basic Sum Insured opted at the time of inception ;which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

i. It is for a life threatening emergency health conditions of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital provided that the transportation is for Medically Necessary Treatment, is certified in writing by a Medical Practitioner, and Domestic Road Ambulance services cannot be provided.
ii. Such air ambulance providing the services, should be duly licensed to operate as such by a competent government Authority.
iii. This cover is limited to transportation from the area of emergency to the nearest Hospital only.
iv. The Sum Insured opted under this cover is within the Basic Sum Insured.
v. We will not cover-
    a. Any transportation from one Hospital to another;
    b. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital.
    c. Any transportation or Air Ambulance expenses incurred outside the geographical scope of India.

5. EMI Protector Benefit for CI :

The Company will pay EMI (s) falling due in respect of the Loan from authorized bank/NBFC (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 :

Section 1

A. Cancer of Specified Severity :

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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 are 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.

B. Alzheimer's Disease :

i. Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes.
ii. 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).
iii. 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.
iv. 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.

C. 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

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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.

D. 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 (PaO2 < 55mmHg); and
iv) Dyspnea at rest.

E. 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.

F. 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.

6. EMI Protector Benefit for prolonged admission :

The Company will pay EMI (s) as specified in the policy schedule falling due in respect of the Loan from an authorized bank/NBFC (Loan account number as stated in Schedule to this Policy) obtained by the Insured member in case the continuous hospitalisation exceeds for the period as stated in the policy schedule , provided a valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

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Specific Conditions applicable to the Sections (EMI Protector Benefit for CI and Prolonged hospitalisation)

i. 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.
ii. Waiting period of 90 days from inception of the Policy will be applicable.
iii. 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.
iv. The Loan account number or EMI's will be considered only if the Loan details are declared before inception of the policy.
v. The cover will get ceased once the claim is accepted and paid for remaining Policy Year.
vi. 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.
vii. The claim will be paid only once in a lifetime for a single Insured Person.
viii. 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
ix. You may still renew the Policy with this cover excluding the claimed Insured Person and/or claimed condition.
x. The Sum Insured opted under this cover is within than the Basic Sum Insured.
xi. In the event of a joint loan, the EMI protector benefit will only be applicable for the insured person who opts for the EMI protect cover, up to their share of the loan amount and the corresponding equated monthly instalment they are paying.

7. Global Cover for Emergency Hospitalization :

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. Waiting period of twenty four (24) months from the time this cover is opted, provided that the policy has been renewed continuously with us without break for you and/or your spouse insuring under this cover.
iv. This cover can only be availed by Insured Person(s) up to the age of 65 years and who are resident(s) of India and are within the geographical boundaries of India during Policy issuance.
v. 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.

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vi. Treatment under this optional cover should be taken at a Hospital or Clinic duly recognized and registered under the applicable law, rules and/or regulations of the region or country where the treatment is taken.

vii. The intimation of such hospitalization to the Company or our Service Provider is within 24 hours of admission

viii. The Emergency Care Medical Expenses incurred during In-patient Hospitalization only shall be covered.

ix. Any Additional Sum Insured as available under Cumulative Bonus/Super Booster (if any) will not be available for Global cover and Hospitalization/day care expenses incurred will be covered only up to the Annual Sum Insured under the Policy.

x. Maternity Benefit, Super Booster, and Restoration benefit will not be available for Global cover.

xi. The cover is available for a maximum period of 60 consecutive days

xii. Expenses incurred for Pre and Post Hospitalization Medical Expenses, Out- patient Treatment or any other Basic Covers/Optional Covers under this Policy shall not be covered under Global cover.

xiii. 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.

xiv. The Sum Insured opted under this cover is within than the Basic Sum Insured.

xv. Liberty General Insurance Limited will not be deemed to provide cover nor 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 Liberty or its parent to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of India, the European Union, United Kingdom, United States of America or other applicable jurisdiction.

xvi. Negatively listed countries and countries exhibiting negative geographies are excluded from the scope of coverage under Global Cover. Negatively listed countries and countries exhibiting negative geographies means those countries / territories / geographies which are placed in the Grey and Black List by the FATF (Financial Action Task Force). For updated list please visit: www.fatf-gafi.org/en/countries/black-and-grey-lists.html.

xvii. Following additional exclusions shall be applicable to this Optional Cover:

a. Any treatment which could have been done on an outpatient basis without any Hospitalization
b. Investigational treatments, Experimental treatment.
c. Convalescence, cure, sanatorium treatment, private duty nursing, treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification centre, home for the aged, mentally disturbed remodeling clinic or any treatment taken in an establishment which is not a recognized Hospital.
d. Any physical, psychiatric or psychological examinations or testing v. Admission for nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner, is medically required & administered as part of in-patient Hospitalization treatment
e. Any expenses incurred on prosthesis, corrective devices external durable medical equipment of any kind.

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f. Cost of artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment. Sleep-apnea and other sleep disorders.
g. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities
h. Cost of issuance of medical certificates and examinations required for employment or travel or any other such purpose
i. Treatment for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, KTP Laser Surgeries, cyber knife treatment, Femto laser surgeries, bioabsorbable stents, bioabsorbable valves, bioabsorbable implants.
j. Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.
k. General debility or exhaustion.
l. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

8. Green Channel Benefit :

The insured person can avail discount of additional 5% on total premium for availing treatment in listed Liberty Green Channel Hospitals only available on our website www.libertyinsurance.in.

Note:

The Company reserves the right to modify, add, or restrict any Network Provider/ Empanelled Service Provider /Green Channel Hospitals for Cashless/Reimbursement Facilities at our sole discretion. Insured Persons are advised to timely check the updated list of Network Provider/ Empanelled Service Provider on our website www. libertyinsurance.in.

In case the insured person avails treatment at a hospital other than Liberty Green Channel Hospitals, an equal co-pay will be applicable on the admissible claim amount. This Co-pay will be over and above any other copay applicable as per the policy terms and conditions.

9. Maternity waiting period reduction :

If the Insured Person has opted for this Optional Cover, the waiting period applicable under the - Maternity Cover shall be reduced from 24 months to 12 months. This

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cover will be available only at the time of opting Optional Cover - Maternity Cover and only for the Annual Sum Insured and Maternity Limit chosen at the time of opting. All the conditions mentioned under the Optional Cover - Maternity Cover shall be applicable to this cover. Once chosen, this optional cover will have to be opted for a period of 2 continuous policy years.

10. Nursing at Home

We will pay You for the expenses incurred by You, up to the amount specified in the policy schedule as per the plan opted. per day up to a maximum of 10 days post Hospitalization for the medical services of a Qualified Nurse at Your residence, provided that the nurse is employed in a Hospital and the engagement of such Qualified Nurse is certified as necessary by a Medical Practitioner and relate directly to any Illness or Injury, covered under the Policy. The Claim under this Optional Cover/add on will be payable only if We have admitted Our liability under “In-patient Treatment” section of the Policy.This cover is limited to one Hospitalization for Individual Policy and maximum upto two Hospitalizations for Floater Plan.

11. OPD cover

We will pay for the expenses related to consultations, relevant Lab investigation and pharmacy on advice of a medical practitioner up to limits specified in the table below, per policy year annually subject to policy terms and condition.

The Company will pay Reasonable & customary charges for the Out Patient treatment incurred by the Insured Person(s) on Individual limit basis during the Policy Year, maximum up to the limit specified in the Schedule to this Policy against this cover, which is separate and not forming part of the Basic Sum Insured as mentioned in the Policy Schedule. These charges will be payable only if the Insured Person (s) consults a specialist consultant/specialist medical practitioner on Outpatient basis for the illness/injury contracted during the policy period. The Company will pay towards following expenses upto the number of Visits to a specialist consultant/specialist medical practitioner as specified in the policy schedule, subject to prescription from the treating specialist consultant/specialist medical practitioner and the number of consultations as mentioned as per the opted OPD limit

- Doctor visit charges
- Nursing Expenses
- Physical Therapy (Physiotherapy) expenses of a specialist Physiotherapist supported by a prescription from the treating specialist consultant/specialist medical practitioner as a medically necessary treatment
- Prescribed Drugs and medicines
- Investigation Services such as Laboratory, X-Ray, Diagnostic tests

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- Dressing, Ordinary splints and plaster casts.

This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

12. Pause the Age

The Premium for your age is paused when you buy the policy, till a claim is paid. In case of multi tenure policies, the premium for the entire tenure will be charged as per the age when the cover had been opted. No additional premium will be charged in the middle of the tenure in case of claims.

At the time of renewal (in case of a claim), the premium will be charged as per the current age of the consumer at renewal.

Members below 50 years only can opt this Optional cover

i. If you add a member to the floater plan, then the premiums will be charged as per the entry age of the eldest member and will pause the premium at that age, till a claim is paid.
ii. If you add a member to an individual plan and convert it into a Floater plan, then the premiums will be charged as per the entry age of the eldest member and will pause the premium at that age, till a claim is paid.
    - If the eldest member is no longer part of the Floater plan, then the Floater premium will be calculated as per the original entry age of the eldest member in the policy amongst the remaining members and pause at that age, till a claim is paid.
    - If a floater plan, splits into multiple policies, then we will carry forward the paused age at which the floater policies were taken by individuals (as per the claim history) in the policies carried forward, till a claim is paid.
    - In a multi individual policy, the age will unpause only for the individuals who claim.
    - In a floater policy, if a claim is paid for anyone in the plan then we will unpause the age for the entire policy.
    - We will consider a claim, if a claim is paid under any base/optional cover opted under the policy.

13. PED Protector :

If the Insured Person has opted for this Optional Cover, the waiting period applicable under Exclusion- Pre-Existing Diseases (Code- Excl01) for any declared and accepted pre-existing diseases shall be reduced to 1 year or 2 year as opted and specified in policy schedule This cover will be available only during inception of the policy and restricted y for the Annual Sum Insured chosen at the time of Policy Inception. The reduced waiting period shall not be applicable for claims made under Optional Cover - Global Cover. Once chosen, this optional cover will continue to be a part of renewal

Specific Conditions applicable to the Section:

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a. Entry age: Below 50 years only can opt this Optional cover
b. Coverage under the policy after the expiry of applicable waiting period for Pre-existing disease and its complications is subject to the same being declared at the time of application and accepted by the Insurer.

14. Room Type Modifier :

This Cover will be provide you option to modify the room rent eligibility to twin-sharing room.This cover shall be available across all Annual Sum Insured options, subject to the following:

If the Insured Person is admitted in a room category/limit that is higher than the one that is specified in the Policy Schedule/ Product benefit table of this policy, then the Insured Person shall bear a ratable proportion of the total Associated medical expenses (including surcharges or taxes thereon) in the proportion of the difference between room rent of the entitled room category to the room rent actually incurred

a. For the purpose of this cover, "Associated medical expenses" shall include room rent, nursing charges, operation theatre charges, fees of medical practitioner including surgeon/anesthetist/ specialist within the same hospital where the insured person has been admitted and will not include the cost of pharmacy and consumables, cost of implants, medical devices and cost of diagnostics.

b. Proportionate deductions are not applicable for ICU charges

c. Proportionate deductions shall not be applicable for hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

15. Super Booster :

100% of base sum insured at the end of each Policy Year in case of Nil claim being initiated in the Policy Year, maximum up to 500% as specified in the policy schedule as per the selected plan.

Scenario 1	Claimed /Not Claimed	SI	CB
Inception/First year	No	2000000	0

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a)

Second year	No	4000000	1000000
Third	No	6000000	2000000
Fourth	No	8000000	3000000
Fifth	No	10000000	4000000
Sixth	No	10000000	5000000
Seventh	No	10000000	5000000

b)

Scenario 2	Claimed /not	SI	CB
Inception/First year	No	2000000	0
Second year	No	4000000	1000000
Third	Yes	6000000	2000000
Fourth	No	6000000	3000000
Fifth	No	8000000	4000000
Sixth	No	10000000	5000000
Seventh	No	10000000	5000000

c)

Scenario 3	Claimed /not	SI	CB
Inception/First year	No	2000000	0
Second year	No	4000000	1000000
Third	Yes	6000000	2000000
Fourth	No	6000000	3000000
Fifth	Yes	8000000	4000000
Sixth	No	8000000	5000000
Seventh	No	10000000	5000000
Eight	Yes/No	10000000	5000000

16. Unlimited Claim :

We will cover the Medical Expenses incurred in respect of Hospitalization of the Insured Person under In-Patient Treatment / Daycare Procedures/Treatment/In-Patient AYUSH Hospitalization/ of the Insured Person for any one claim during the lifetime of the Policy without any limits on the Annual Sum Insured, subject to the following conditions:

i. The time period to opt for this optional cover shall be only during inception

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ii. This cover is applicable only for one claim in the lifetime of the Policy, irrespective of Policy Tenure or Policy Type (Individual or Floater), and should be admissible under In-patient Treatment/Daycare Procedures/Treatment/In-patient AYUSH Hospitalization.
iii. All the conditions applicable to the above-mentioned Basic Covers shall be applicable to this Optional Cover.
iv. Once opted, the optional cover has to be opted continuously by the Insured Person until any one claim is made under this cover. If the Insured Person opts out of this cover during any renewal, the same cannot be opted again.
v. Once a claim has been made under this Optional Cover, the cover will cease to exist and cannot be opted again upon subsequent renewals.
vi. The Total Sum Insured (Annual Sum Insured + Cumulative Bonus (if accrued) + Super Booster (if opted and accrued) shall be utilized as per following sequence in event of a claim under this Optional Cover: -
    1. Annual Sum Insured
    2. Cumulative Bonus
    3. Super Booster
vii. After utilization of all the above-mentioned Sum Insured, the Total Sum Insured shall be reduced to zero for that Policy Year following the payment of claim under unlimited claim.
viii. Voluntary Co-payment and Deductible if opted by the Insured Person shall be applicable under this Optional Cover.
ix. This cover will not be applicable in case of claims lodged under Optional Cover : Global Cover.
x. Room category applicable under this cover shall be capped at Single Private AC room unless the Insured Person has opted for Optional Cover - Room Modifier.

17. 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.

17.1 List of Vector Borne Diseases:

I. Dengue Fever,
II. Malaria,
III. Chikungunya
IV. Japanese Encephalitis,

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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.

17.2 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 –

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

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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-

Pre-existing Lymphatic Filariasis at the time of taking the policy is excluded for lifetime 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.

17.3 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 **Single Year Policy** admission would apply for the specific ailment of which a claim has been paid.

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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.

18. Voluntary Co-payment :

Depending on the percentage of Co-pay opted, each and every claim under the Policy shall be subject to a Copayment of 5%, 10%,15% 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. This Co-pay will be over and above any other copay applicable as per the policy terms and conditions

19. Voluntary Deductibles :

The Insured Person can choose Voluntary Deductible and avail subsequent discount on premium as per selected plan.

- The Insured Person will be liable to bear the specified Deductible amount, if Voluntary Deductible opted as mentioned in Policy Schedule.
- Voluntary Deductible will apply on aggregate basis for all hospitalisation expenses during the policy year which fall under basic cover, except wellness benefit.
- The deductible will apply on individual basis in case of individual policy and on floater basis in case of floater policy.
- Voluntary Deductible once chosen, can be modified only during Renewal subject to underwriting.
- Insured can choose either Voluntary deductible or voluntary co-payment.

Part IV: Renewal Features

1.a Cumulative Bonus:

Please refer section below:

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Part II: Scope of Cover D.BENEFITS COVERED UNDER THE POLICY SCOPE OF COVER 14.Cumulative Bonus

1.b Discount in Renewal Premium :

The Insured Person who do not make claim, may choose for availing Discount in renewal premium in lieu of auto increase in Basic Sum Insured (Cumulative Bonus) for every claim free Policy year. If insured opt for this discount during renewal, he/she will not be eligible for Cumulative Bonus as mentioned above in Part IV a.

In event of claim between renewal date and actual risk start date of renewed policy, the discount offered during renewal will be remitted from the claim or collected from insured/proposer.

2. Renewal Health Check-up :

The Insured Person/s above18 years of age is/are entitled to a free health check-up after a block of 2 renewals with us, on Cashless basis, at a diagnostic center specified by the Company every year of continuous yearly Policy renewal with Us irrespective of the claims made, 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.

The limit is the maximum per policy in case of floater policy and per insured person in case of individual policy

This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

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

` 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:

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

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i. 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 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.

ii. ***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

Two Year (24 months) Waiting Period	
Cataract	Calculus diseases of Gall bladder and Urogenital system
Benign Prostatic Hypertrophy	Joint Replacement due to Degenerative condition,

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Hernia	Surgery for prolapsed inter vertebral disc unless arising from accident
Hydrocele	Age related Osteoarthritis and Osteoporosis
Fistula in anus	Spondylosis / Spondylitis
Piles	Surgery of varicose veins and varicose ulcers.
Sinusitis and related disorders	Treatment for correction of eyesight (laser surgery) due to refractive error
Fissure	Maternity (if opted)
Gastric and Duodenal ulcers	Gout and Rheumatism
Internal tumors, cysts, nodules, polyps , breast lumps (unless malignant)	Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus
Polycystic ovarian diseases	Skin tumours (unless malignant)
Benign ear, nose and throat (ENT) disorders and surgeries, adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty	Dilatation and Curettage (D&C);
Treatment of Obesity	

iii. 30-day waiting period- Code- Excl03 :

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

iv. Investigation & Evaluation – Code-Excl04 :

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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.

v. 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:

a. 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.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

vi. Obesity/ Weight Control: Code- Excl06 :

Expenses related to the surgical treatment of obesity that does not fulfil all the following 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

vii. 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.

viii. 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

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ix. 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.

x. 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.

xi. 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.

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

xiii. 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

xiv. 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

xv. Refractive error: Code – Excl15

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

xvi. 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.

xvii. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

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

xviii. Maternity: Code Excl18

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

Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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

i. 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.

ii. Dental treatment, dentures or Surgery of any kind unless necessitated due to accident and requiring minimum 24 hours hospitalisation. Any treatment related to Gum Disease or Tooth Disease or Damage unless related to irreversible bone disease involving jaw which cannot be treated in any other way.

iii. 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.

iv. 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. Cost of Cochlear implant unless necessitated by accident or require intra-operatively. Cost of Hearing aid including Optometric Therapy

v. 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.

vi. External Congenital Anomaly.

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

viii. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy unless specifically mentioned in your policy schedule.

ix. Treatment received outside India unless specifically mentioned in your policy schedule.

x. 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.

xi. 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.

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

xiii. Cost of issuance of medical certificates and examinations required for employment or travel or any other such purpose

xiv. 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.

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

a. 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: 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

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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.

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

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

xviii. This policy shall not cover expenses incurred on medicines or pharmaceuticals sourced from outside India, regardless of where the treatment is taken. Any claims expenses related to but not limited to the purchase of medicines, availing medical services like Consultation, Procedure, Investigation etc from international sources which not registered with Medical council of India or any such similar services which fall outside of Indian Jurisdiction will not be payable, unless Global Cover availed

Part VI: General Conditions

A. 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) :

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a) The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

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 interest at bank rate plus 2 percent from the date of receipt of intimation to till the date of payment. Such interest shall be suo-moto paid by the insurers.

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 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:

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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	

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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 IRDAI 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 IRDAI 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. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

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

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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 Instalments:

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.

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iii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.
v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vi. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.
vii. The total premium applicable for a yearly or long term policy tenure shall be collected not later than first year of the policy.

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

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.

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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 Maharashtra	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 prevailing Insurance Ombudsman Rules. 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 - bimabharosa.irdai.gov.in

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

17. Nomination :

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

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

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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 unless specifically mentioned in your policy schedule & all the benefits under the policy shall be payable in Indian rupees only.

7. Governing Laws, Territorial Jurisdiction and Territorial Limit :

i. This Policy/Certificate of Insurance shall be exclusively governed and construed as per laws of India and all disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Group Policy/Certificate of Insurance shall be, determined by the Indian court and in accordance to Indian laws.

ii. All medical treatment for the purpose of the Certificate of Insurance will have to be taken in India only.

iii. We cover Medical Expenses for treatment availed outside India only if opted for Optional Cover- Global Cover - emergency Care only.

iv. Our liability to make any payment shall be to make payment within India and in Indian Rupees only.

The section headings of this Policy and Certificate of Insurance are included for descriptive purposes only and do not form part of this Policy and Certificate of Insurance for the purpose of its construction or interpretation.

8. Notice :

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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.

9. Electronic Transaction :

The Insured agrees to adhere to and comply with all such terms, conditions and exclusions as the Company may prescribe from time to time, and hereby agrees and validates that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, has his concurrence and full understanding of the terms and conditions affecting this Contract and shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure adherence to conditions of section 41 of the Insurance Act 1938 with full disclosures on terms, conditions and exclusions. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and sent to the Insured Person, duly validated/confirmed by the Insured Person.

10. Customer Service :

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

11. Zone based premium :

For the purpose of premium computation, the country has been divided into below zones,

Zone	Districts
Zone A	Mumbai (including Mumbai Metropolitan Region), Jalna, Delhi (including National Capital Region, Noida, Faridabad, Ghaziabad, Gurgaon,Barabanki), Ahmedabad,Gandhinagar,Surat,Rupnagar, Nashik, Jhajjar,Panipat,Meerut,Palwal.

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Zone B	Vadodara, Rajkot,Karnal,Hisar,Srinagar, Ludhiana, Sonipat,Rohtak, Gwalior Hyderabad,RangaReddy and Pune
Zone C	Tiruppur,Baghpat,Hapur,Shamli,Mysuru,Lucknow,Dehradun,Bangalore,Bengaluru Rural,Bengaluru Urban,Chennai,Barwani,Aurangabad(Mh),Beed,Kolhapur,Erode,Botad,Bhiwani,Nuh.
Zone D	Anand,Wayanad,Raipur,Jabalpur,Udaipur,Chengalpattu,Madurai,Namakkal,Tiruchirappalli,Palghar,Karimnagar,Warangal Urban,Sirsa,Shimoga,Raigad(Mh),Agra,Muzaffarnagar,Udham Singh Nagar,Darjeeling,Kozhikode,Jalgaon,Jalandhar,Kurukshetra,Kanpur Nagar,Ernakulam,Amritsar,Bathinda,Yamunanagar,Bulandshahr,Kanniyakumari and Kolkata.
Zone E	Vellore,Kollam,Thiruvananthapuram.
Zone F	Ahmednagar,Bhopal,Indore,Panchkula,Jaipur,Coimbatore.
Zone G and beyond	Solapur, Tumkur, Satara and Rest of India

The premium will depend on the city of residence and pin code of the insured person. Please inform us immediately in case of any change in the same. Not doing so, may impact your claim admissibility. Policy issued to the Insured with Sum Insured less than INR 10 Lacs and those belonging to Zones B, C, D, and onward cities, and if the Insured availed medical treatment from the Hospital of Zone A, then the Insured has to bear a 10% co-payment on the admissible claim amount. This Copay will be irrespective of any other Copay applicable as per the policy terms and conditions.

B. OTHER TERMS AND CONDITIONS

1. Entry Age :

Minimum entry Age: Adult –18 years; Dependent Child -91 days
Maximum entry Age: No Entry Restriction.

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

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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.

4. Increase in Sum Insured or Change in Plan/Optional Cover :

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

5. 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.

6. Sub-standard Risk :

Proposals where the Health status is adverse, as revealed in the Proposal form and/or followed by health checkup may be accepted at the sole discretion of the Company with an increased risk rating which shall not exceed 100% of normal slab premium per diagnosis / medical condition and not over 200% of normal slab premium per person. Applicable for all subsequent renewal(s) involving age slab changes and increase in Sum Insured. If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing, then Pre-Existing Condition Exclusion (1.c) shall be applicable. In all such cases, we would send a communication letter to the Proposer and obtain his/her consent before acceptance of the Proposal.

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7. Pre Policy Health Check Up :

The Company may require Individuals to undergo Pre Policy health check-up based on the Sum Insured or age bands or an adverse medical history revealed in the Proposal form at our network list of diagnostic centers as available on our website. The result of these tests will be valid for a period of 3 months from the date of tests performed. The Company reserves its right to require any individual to undergo such medical tests or any further additional tests, at the sole discretion of the Company to determine the acceptance of a Proposal. If the proposal is accepted we shall refund 50% of the health check-up cost (on our pre agreed rates with the network provider). This age limit may be relaxed for specific channels or plans depending on judgement of medical underwriter.

8. Discount Parameters :

a. **Family Floater Discount** : In case it is a family floater policy, a discount shall be applicable as per the family size and highest age.
b. **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.
c. **Employee Discount**: 10% discount if the client is an employee of the Company
d. **Direct Policy Purchase Discount**- 10% discount will be given if you are purchasing this Policy through Our Website.
e. **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.
f. **Discount for Female insured**: Avail discount of 4% for one or many Female insured.
g. Liberty's Group Policyholder Cover Discount
h. The Insured person can avail Direct discount of 5% on premium if proposer declares the details of Liberty's Group Health Insurance Policy he/she covered.

9. 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

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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.

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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.

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Liberty General Insurance Ltd.
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013,
Phone: +91 226700 1313 Fax: +91 226700 1606
Toll Free : 1800 266 5844
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656
Website Link: www.libertyinsurance.in

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**

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- 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 In-patient Treatment documents

  - 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 Hospitalization treatment

- **Restoration of Basic Sum Insured**

  Same as In-patient Hospitalisation treatment

- **Recovery Benefit**

  Same as In-patient Hospitalisation treatment.

- **Domiciliary hospitalization**

  Same as In-patient Hospitalisation treatment

- **Bariatric surgery**

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Same as In-patient Hospitalisation treatment

- **Modern surgeries**

  Same as In-patient Hospitalisation treatment

- **Maternity Benefit**

  Same as In-patient Hospitalisation treatment

- **Accidental Sum Insured**

  In addition to the In-patient Treatment documents:

  - Copy of the First Information Report from Police Department / Copy of the MedicoLegal 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.

- **Emergency Domestic Medical Evacuation**

  - 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.

- **Unlimited claim**

  Same as In-patient Hospitalisation treatment

- **Nursing at Home**

  In addition to the In-patient Treatment documents:

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- 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 for CI and Prolonged Admission**

  - 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

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- **Domestic Travel Plus**

  Same as In-patient Hospitalisation treatment

  - Flight itinerary and Boarding pass and/or ticket details as applicable.

- **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

- **OPD Treatment**

  - Duly filled and signed Claim Form
  - Photocopy of ID card / Photocopy of current year policy
  - Consultation letter and subsequent Prescriptions.
  - Original bills, original payment receipts
  - In case of a Claim towards Physiotherapy, need to be supported by a prescription from the treating specialist consultant/specialist medical practitioner as a medically necessary treatment

- **Compassionate Travel**

  - Flight itinerary and Boarding pass and/or ticket details as applicable.
  - KYC of the immediate family member

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.

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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 15 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,
f. All claims will be settled as 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 under relevant 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

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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

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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)

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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

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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

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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

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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

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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

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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

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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

Grievance Redressal

Annexure B

City	Jurisdiction	Contact Details
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001.	Gujarat, Dadra & Nagar Haveli, Daman and Diu.	Tel: 079-25501201/02 Email: oio.ahmedabad@cioins.co.in
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, Ground Floor, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078.	Karnataka.	Tel: 080-26652048 / 26652049 Email: oio.bengaluru@cioins.co.in
BHOPAL Office of the Insurance Ombudsman, 1st Floor, Jeevan Shikha, 60-B, Hoshangabad Road, Bhopal – 462 011.	Madhya Pradesh, Chhattisgarh.	Tel: 0755-2769201 / 2769202 / 2769203 Email: oio.bhopal@cioins.co.in
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar – 751 009.	Odisha.	Tel: 0674-2596461 / 2596455 / 2596429 / 2596003 Email: oio.bhubaneswar@cioins.co.in
CHANDIGARH Office of the Insurance Ombudsman, SCO 20–27, Ground Floor, Sector 17-A, Chandigarh – 160 017.	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, UTs of J&K, Ladakh & Chandigarh.	Tel: 0172-2706468 Email: oio.chandigarh@cioins.co.in
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tamil Nadu, Puducherry (including Karaikal).	Tel: 044-24333668 / 24333678 Email: oio.chennai@cioins.co.in

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DELHI Office of the Insurance Ombudsman, 2/2A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Delhi and districts of Haryana – Gurugram, Faridabad, Sonepat & Bahadurgarh.	Tel: 011-46013992 / 23213504 / 23232481 Email: oio.delhi@cioins.co.in
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, S.S. Road, Guwahati – 781 001.	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland & Tripura.	Tel: 0361-2632204 / 2602205 / 2631307 Email: oio.guwahati@cioins.co.in
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.	Andhra Pradesh, Telangana, Yanam and part of the Union Territory of Puducherry.	Tel: 040-23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: oio.hyderabad@cioins.co.in
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Building, Ground Floor, Bhawani Singh Marg, Jaipur – 302 005.	Rajasthan.	Tel: 0141-2740363 Email: oio.jaipur@cioins.co.in
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash (LIC Building), Opp. Maharaja's College Ground, M.G. Road, Kochi – 682 011.	Kerala, Lakshadweep, Mahe (part of UT of Puducherry).	Tel: 0484-2358759 Email: oio.ernakulam@cioins.co.in
KOLKATA Office of the Insurance Ombudsman, Hindustan Building Annexe, 7th Floor, 4, C.R. Avenue, Kolkata – 700 072.	West Bengal, Sikkim, Andaman & Nicobar Islands.	Tel: 033-22124339 / 22124341 Email: oio.kolkata@cioins.co.in
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow – 226 001.	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Prayagraj, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Ghazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Shravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkar Nagar, Sultanpur, Maharajganj, Sant Kabir Nagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Chandauli, Ballia, Siddharthnagar.	Tel: 0522-4002082 / 3500613 Email: oio.lucknow@cioins.co.in
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz (West), Mumbai – 400 054.	Wards under Mumbai Metropolitan Region excluding M/E, M/W, N, S and T (covered under Thane Ombudsman) and areas of Navi Mumbai.	Tel: 022-69038800 / 27 / 29 / 31 / 32 / 33 Email: oio.mumbai@cioins.co.in
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Gautam Buddh Nagar, UP – 201 301.	Uttarakhand and districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar,	Tel: 0120-2514252 / 2514253 Email: oio.noida@cioins.co.in

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	Auraiya, Pilibhit, Etawah, Farrukhabad, Firozabad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kasganj, Sambhal, Amroha, Hathras, Saharanpur.	
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna – 800 001.	Bihar, Jharkhand.	Tel: 0612-2547068 Email: oio.patna@cioins.co.in
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Building, 3rd Floor, C.T.S. Nos. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	Goa and Maharashtra excluding Navi Mumbai, Thane, Palghar, Raigad districts and Mumbai Metropolitan Region.	Tel: 020-24471175 Email: oio.pune@cioins.co.in
THANE Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) – 400 604.	Navi Mumbai, Thane, Raigad, Palghar districts and Mumbai wards M/East, M/West, N, S and T.	Tel: 022-20812868 / 69 Email: oio.thane@cioins.co.in

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