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LIBERTY HOSPI-CASH CONNECT POLICY
POLICY WORDINGS

Preamable & Operative Clause

Liberty General Insurance (hereinafter called the **"Company","We, Our, or Us"**) will provide insurance cover to the person(s) (hereinafter called the **"Insured","You, Your, or Yourself"**) based on the information provided in the Proposal form and payment of agreed premium within such time, as may be prescribed under the provisions of the Insurance Act, 1938, for the Policy Period stated in the Schedule or during any further period for which the Company may accept payment for the Renewal or extension of this Policy and subject to the terms, conditions, provisions, exclusions 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.

A. Interpretations & Definitions

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

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

2. **"Age"** means the completed age of the Insured Person as on his last birthday.

3. **"Any One Illness"** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

4. **"Alternative treatments"** are forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

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

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"** means which is not in the visible and accessible parts of the body

   b. **"External Congenital Anomaly"** means which is in the visible and accessible parts of the body

7. **"Day Care Centre"** means any institution established for day care treatment of sickness 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

8. **"Day care Procedure/treatment"** refers to medical treatment, and/or surgical procedure which is
   a) undertaken under General or Local Anesthesia in a hospital/day care centre for less than 24 hours because of technological advancement, and
   b) which would have otherwise required hospitalization of more than 24 hours.

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

9. **"Dental Treatment"** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

10. **"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.

11. **"Endorsement"** means written evidence of change to the Policy including but not limited to increase or decrease in the period, extent and nature of the cover agreed by Us in writing.

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

13. **"Grace period"** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

14. **"Hospital"** means any institution established for in-patient care and day care treatment of sickness 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 the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
   a. has qualified nursing staff under its employment round the clock;
   b. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
   c. has qualified medical practitioner (s) in charge round the clock;
   d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
   e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

15. **"Hospitalization"** means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

16. **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

    a. **Acute Condition:** is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

    b. **Chronic Condition:** is defined as a disease, illness or injury that has one or more of the following characteristics: it needs on-going or long term monitoring through consultations, examinations, check-ups, and/or tests - it needs on-going or long term control or relief of symptoms- it requires your rehabilitations or for you to be specially trained to cope with it - it continues indefinitely - it comes back or is likely to come back.

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

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

19. **"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.

20. **"Insured/ You/ Your/ Yourself"** means the employer or legally constituted group named in the Schedule who has concluded this Policy with Us.

21. **"Insured Person/s"** means the person/s named in the Schedule to the Policy, who is/are Indian Resident /s and for whom the insurance is also proposed and appropriate premium paid.

22. **"Medical Advise"** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

23. **"Maternity expense/treatment"** shall include :
    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.

24. **"Medical expenses"** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness

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or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

25. **"Medical Practitioner"** means a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license provided that this person is not a member of the Insured Person's family.

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

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

28. **"Notification of Claim"** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

29. **"OPD treatment"** is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

30. **"Policy"** means this document of Policy describing the terms and conditions of this contract of **insurance** including the Company's covering letter to the Insured if any, the Schedule attached to and forming part of this Policy, the Insured's Proposal form and any applicable endorsement attaching to and forming part thereof either at inception or during the period of insurance.

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

32. **"Policy year"** means a year following the Commencement Date and its subsequent annual anniversary.

33. **"Portability"** means transfer by an individual health insurance policy holder (including family cover) of the credit gained for pre-existing conditions and time bound exclusions if he/she chooses to switch from one insurer to another.

34. **"Pre-existing Condition"** means any condition, ailment or Injury or related conditions for which the Insured Person had signs or symptoms, and/ or were diagnosed, and or received medical advice or treatment within 48 months prior to the first policy issued by Us.

35. **"Proposal and Declaration Form"** means any initial or subsequent declaration made by the Insured/ Insured Person/s and is deemed to be attached and forming part of this Policy.

36. **"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.

37. **"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.

38. **"Renewal"** Renewal defines 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 all waiting periods.

39. **"Restore Sum Insured"** The amount is restored accordance with Section B2.8 of this Policy.

40. **"Room Rent"** means the amount charged by a hospital for occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

41. **"Service Provider"** means a Health care provider appointed by Insurer to provide services as enlisted under Section B2.11 of the Policy.

42. **"Schedule"** means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured in respect of each Insured Person (s), the period, Coverage and the limits to which benefits under the Policy are subject to.

43. **"Surgery"** 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.

44. **"Sum Insured"** means the amount stated in the policy Schedule as such or limited to the specific insurance details in any Section of this Policy. The Sum Insured shall be subject at all times to the terms and conditions of the Policy, including but not limited to the exclusions and any additional limitations noted in the wording of each Section.

45. **"Third Party Administrator or TPA"** means any person who is licensed under the IRDA (Third Party Administrator- Health Services) Regulations, 2001 by the Authority, and is engaged , for a fee or remuneration by an Insurance Company, for the purpose of providing health Services.

46. **"Threshold limit"** is a minimum amount of medical expenses that must be incurred by the Insured for the insurance coverage to be triggered under 'Special Care on listed Minor Surgery' (B.6 of this document) and 'Special Care on listed Major Surgery' (B.7 of this document).

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

B. Scope Of Cover

The Company undertakes to pay the Insured Person against disease or any one illness or any bodily injury due to accident 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 medical expenses for medical/surgical treatment at any Hospital/Nursing Home in India as an inpatient, subject to the terms, conditions, exclusions and definitions contained herein or endorsed.

The Company will pay the benefit as mentioned in the Schedule to the Policy and not exceeding the Sum Insured mentioned therein.

Claims made in respect of any of the benefits below will be subject to the Sum Insured and is reflected only if noted as such in the Schedule to this Policy.

B1. Basic Cover

This Policy offers selection of either of the cover as mentioned below under Section B1.1 and 2.

1. **Daily Hospital Cash Benefit (DHC):** In case of hospitalization of the Insured/Insured Person/s for a medically necessary treatment due to any illness or accidental bodily injury sustained or contracted within the Policy Period, for a continuous period of more than 24 hours, a daily hospital cash benefit as mentioned in the Schedule to the Policy, shall be payable for every completed 24 hours of hospitalization, subject to per event/Hospitalisation limited to 30 days (inclusive of both ICU & Non-ICU stay) and up to balance Sum Insured for that Policy year.

2. **Daily Hospital Cash (DHC) - Accident:** In case of hospitalization of the Insured/Insured Person/s due to accidental bodily injury and/or any illness/sickness arising due to consequences of accidental bodily injury sustained or contracted during the Policy Period, for a continuous period of more than 24 hours, a Daily Hospital Cash – Accident as mentioned in the Schedule to the Policy shall be payable, for every completed 24 hours of hospitalization subject to per event / Hospitalisation limited to 30 days (inclusive of both ICU & Non-ICU stay) and upto balance Sum Insured for that Policy year.

B2. Flexi - Choose and Pick Covers

The Policy would also offer Flexi covers as listed below which are available under different plans of Hospi-Cash Connect or as optional covers under Hospi-Cash Connect Flexi and specified so in the Schedule to this Policy. For multi -Year Policy Period the benefit/s shall be available separately for each Policy year.

1. **Double Accident Benefit (DAB):** In case of hospitalization of the Insured/Insured Person/s due to accidental bodily injury and/or any illness/sickness arising due to consequences of accidental bodily injury sustained or contracted during the Policy Period, for more than 3 consecutive completed days, then the Daily Hospital Cash benefit as mentioned in the Schedule to the Policy shall be doubled and the Insured would be entitled to a Double Accident Benefit payable for every completed 24 hours of hospitalization, subject to per event/Hospitalisation limited to 30 days(inclusive of both ICU & Non-ICU stay), payable upto balance Sum Insured for that Policy year.
   If this cover is admissible, We will then not pay separately for the Daily Hospital Cash benefit or Daily Hospital Cash- Accident under SectionB1 of the Policy.

2. **Double ICU Benefit (DIB)-Sickness:** In case the Insured/Insured Person/s is/are required to be admitted in an Intensive Care Unit (ICU) for a medically necessary treatment due to any illness not traceable to accidental bodily injury, for a continuous period of more than 24 hours, a Daily Hospital Cash Benefit as mentioned in the Schedule to the Policy shall be doubled and payable for every completed 24 hours in an ICU, subject to per event/Hospitalisation limited to 30 days(inclusive of both ICU & Non-ICU stay), payable upto balance Sum Insured for that Policy year.

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If this cover is admissible, We will then not pay separately for the Daily Hospital Cash benefit or Daily Hospital Cash- Accident under Section B1of the Policy

3. **Double ICU Benefit (DIB)-Accident:** In case the Insured/Insured Person/s is/are required to be admitted in an Intensive Care Unit (ICU) for a medically necessary treatment due to accidental bodily injury and includes any illness/sickness arising from such accidental bodily injury sustained or contracted within the Policy Period, for a continuous period of more than 24 hours, a Daily Hospital Cash Benefit or Daily Hospital Cash - Accident as mentioned in the Schedule to the Policy shall be doubled and payable for every completed 24 hours in an ICU, subject to per event/Hospitalization limited to 30 days(inclusive of both ICU & Non-ICU stay), payable upto balance Sum Insured for that Policy year.
   If this cover is admissible, We will then not pay separately for the Daily Hospital Cash benefit or Daily Hospital Cash- Accident under Section B1. of the Policy

4. **Recovery Benefit:** Incase of hospitalization of the Insured/Insured Person/s for a medically necessary treatment due to any illness or accidental bodily injury sustained or contracted within the Policy Period, for more than 15 consecutive days of hospitalization then a one time lump sum payment as mentioned in the Schedule to the Policy will be payable towards Recovery in addition to Daily Hospital Cash Benefit and/or any other lump sum benefits applicable subject to the maximum of balance Sum Insured for that Policy year.
   For a long term Policy year this benefit shall be available separately for each Policy Year.

5. **Convalescence benefit:** If in case 2 or more family members covered under Our "Hospi-Cash Connect" Policy are hospitalized due to the same accident sustained or contracted within the Policy Period, for more than 24 consecutive hours, and the hospitalization of the members is within a weeks' time from the first date of accident of an Insured member, then a onetime lump sum payment, as mentioned in the Schedule to the Policy will be payable towards convalescence individually and separately to all the member / hospitalized due to same accident, in addition to the Daily Hospital Cash Benefit and/or any other lump sum benefits applicable subject to the maximum of balance Sum Insured for that Policy year.

6. **Special Care on Listed Minor Surgeries:** In case the Insured/Insured Person/s is/are hospitalized and has incurred expenses more than the threshold limit of INR 50,000, for a medically necessary treatment due to any illness or accidental injury involving minor Surgical Procedure/s as listed below and performed within the Policy Period, then a onetime lump sum payment as specified under Schedule of the Policy shall be payable, in addition to Daily Hospital Cash Benefit and/or any other lump sum benefits applicable subject to the maximum of balance Sum Insured for that Policy year.
   This benefit is available only once for each of the listed minor surgeries performed during the Policy Period.

List of Minor Surgeries	
Sr. No	**Minor Surgeries**
1	Removal of Appendix
2	Removal of Renal Calculi
3	Haemorrhoidectomy
4	Removal of Gall Stone/Gall Bladder
5	All types of Hernia repair
6	Benign Prostatic Hypertrophy(TURP)

7. **Special Care on Listed Major Surgeries:** While this Policy is in force, in case the Insured/Insured Person/s is/are hospitalized and has incurred expenses more than the threshold limit of INR 2,00,000,for a medically necessary treatment due to any illness or accidental injury involving a Major Surgical Procedure as listed below and performed within the Policy Period, then a one time lump sum payment as specified under Schedule of the Policy shall be payable, in addition to Daily Hospital Cash Benefit and/or any other lump sum benefits applicable subject to the maximum of balance Sum Insured for that Policy year.
   This benefit is available only once for each of the listed major surgeries performed during the Policy Period.

List of Major Surgeries	
Sr. No	**Major Surgeries**
1	CABG- Coronary Artery Bypass Grafting
2	Angioplasty – PTCA
3	Brain surgery including Craniotomy, tumor removal and intracranial drainage
4	Major organ transplant (Heart, Lung, Liver, Pancreas, Kidney)
5	Bone marrow transplant Surgery
6	Post traumatic Surgeries including Skull fracture, amputation of upper and / or lower limb, pelvis fracture / hip fracture, compound communicated fracture of any part where ORIF is required.
8	Knee ligament surgery - trauma related
9	Hip replacement (traumatic hip injury- both partial and total)
10	Spinal surgeries
11	Heart valve replacement
12	Surgery of Aorta
13	Thyroidectomy

8. **Restore Benefit:** The Policy provides, a Restore Sum Insured equivalent to the opted Sum Insured as per the Plan selected, if the Sum Insured is exhausted due to claims made and paid during the Policy or made during the Policy year and accepted as payable, for the particular Policy year, provided that:
   a. The Restored Sum Insured will be utilized only after the selected Sum Insured have been completely exhausted in that Policy year.
   b. The Restored Sum Insured will be available during the Policy year till it is exhausted completely.
   c. Any unutilized restored amount cannot be carried forward to any subsequent Policy year.
   d. The total amount of restored Sum Insured shall not exceed the selected Sum Insured for that Policy year and shall be available for all the covers specified under the Policy Schedule.
   e. In case of Portability, the credit for Sum Insured would be given only to the extent of Sum Insured selected at First Policy Inception Date.

9. **Double Critical Illness Benefit (DCI):** In case of hospitalization of the Insured/Insured Person/s for a medically necessary treatment as an inpatient in a Hospital for more than 24 consecutive hours for any of the listed surgical procedure/illness as defined under Listed Critical Illness herein below contracted within the Policy Period , a daily hospital cash benefit as mentioned in the Schedule to the Policy will be doubled and payable for every completed 24 hours of hospitalization, to the maximum of balance Sum Insured for that Policy Year, subject to all of the following conditions are satisfied,
   a. The Insured Person experiences a Critical Illness specifically listed and defined in this Policy;
   b. The signs or symptoms of the Critical Illness experienced by the Insured/ Insured Person commenced beyond waiting period of more than 90 days following the First Policy Inception Date with us;
   c. None of the General Exclusions specifically contained in this Policy applies and
   d. Critical Illness coverage is available for Individual Insured Person and up to the Sum Insured as specified in the Schedule to this Policy
   e. Per event Hospitalisation is limited to 30 days;
   f. Payable upto balance Sum Insured for that Policy year;
   g. This benefit is available only once per listed Critical Illness in the entire Policy duration of the Insured/ Insured Person/s with Us- however it shall be available for other listed Critical illnesses contracted within the Policy Period but not arising due to complications/consequences of any reported and paid listed Critical Illness/s within the entire Policy duration of the Insured/ Insured Person/s with Us
   h. Payment under this benefit will be made provided that the:
      i. Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period
      ii. Insured Person survives for at least 30 days following such diagnosis
   i. If this cover is admissible, We will then not pay separately for the Daily Hospital Cash benefit or Daily Hospital Cash- Accident under Section B1 of the Policy

Covered Critical Illness:

C1	Cancer of specified severity
C2	Kidney Failure requiring regular Dialysis
C3	Multiple Sclerosis with persisting symptoms
C4	Major Organ/Bone marrow Transplant
C5	Open Heart Valve Replacement/Repair of Heart Valves
C6	Open Chest Coronary Artery Bypass Graft
C7	Stroke resulting in permanent symptoms
C8	Permanent Paralysis of Limbs
C9	First Heart Attack of specified Severity
C10	Benign Brain Tumor
C11	Parkinson's Disease
C12	Alzheimer's Disease
C13	End Stage Liver Disease
C14	Surgery of Aorta
C15	Major Burns
C16	Loss of Speech
C17	Deafness
C18	Coma of specified severity

C1 Cancer of specified severity
A malignant tumour characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy &

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confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded :

a. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
b. Any skin cancer other than invasive malignant melanoma
c. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
d. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
e. Chronic lymphocyticleukaemia less than RAI stage 3
f. Micro carcinoma of the bladder
g. All tumours in the presence of HIV infection

C2 Kidney Failure requiring regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

C3 Multiple Sclerosis with persisting symptoms

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

1. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
3. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart

Other causes of neurological damage such as SLE and HIV are excluded.

C4 Major Organ Transplant/Bone Marrow Transplant

The actual undergoing of a transplant of:

1. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

2. Human bone marrow using haematopoietic stem cells
   The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

a. Other stem-cell transplants
b. Where only islets of Langerhans are transplanted

C5 Open Heart Valve Replacement/Repair of Heart Valves

The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

Catheter based techniques including but not limited to, balloon valvotomy / valvuloplasty are excluded.

C6 Open chest Coronary Artery Bypass Graft (CABG)

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures
b. Any key-hole or laser surgery.

C7 Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain.

Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.

The following are excluded:

a. Transient ischemic attacks (TIA)
b. Traumatic injury of the brain
c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

C8 Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

C9 First Heart Attack of specified Severity

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis for this will be evidenced by all of the following criteria:

1. history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
2. new characteristic electrocardiogram changes
3. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

a. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;
b. Other acute Coronary Syndromes
c. Any type of angina pectoris

C10 Benign Brain Tumor

A benign tumor in the brain where all of the following conditions are met:

1. It is life threatening
2. It has caused damage to the brain
3. The realization of surgery has to be confirmed by a Neurologist or Neurosurgeon or if inoperable, it has caused permanent neurological deficit such as (but not restricted to) characteristic symptoms of increased intracranial pressure such as papilloedema, mental seizures and sensory impairment and for the purpose of this benefit, the word 'permanent' shall mean beyond the hope of recovery with current medical knowledge and technology.
4. Its presence must be confirmed by a Neurologist or Neurosurgeon and supported by findings on Magnetic Resonance Imaging (MRI), Computerised Tomography or other reliable imaging technique.

The following are excluded:

a. Cysts;
b. Granulomas or;
c. Vascular malformations;
d. Haematoma;
e. Tumors of any pituitary gland or spinal cord; acoustic nerve (acoustic neuroma)

C11 Parkinson's Disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease and all of the following conditions are met and confirmed by a Neurologist and supported by Our Appointed Doctor.

1. which cannot be controlled with medication
2. signs of progressive impairment; and
3. inability of the Insured person to perform at least 3 of the 6 activities of daily living activities must be supported by all of the following conditions;

The living (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months

Activities of Daily Living:

a. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
d. Mobility: the ability to move indoors from room to room on level surfaces;
e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
f. Feeding: the ability to feed oneself once food has been prepared and made available

Drug induced or toxic causes of Parkinsonism are excluded.

C12 Alzheimer's Disease

Alzheimer's Disease is a progressive degenerative illness of the brain, characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes.
Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's Disease, resulting in progressive significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person.
The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our Appointed Doctor.

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The following are excluded:

a. non-organic diseases such as neurosis and psychiatric illnesses;
b. alcohol related brain damage;
c. any other type of irreversible organic disorder/dementia.

C13 End Stage Liver Disease

End stage liver disease or cirrhosis of liver means end stage of liver failure that causes at least one of the following:

1. uncontrollable ascites
2. permanent jaundice
3. oesophageal or gastric varices
4. hepatic encephalopathy

For the purpose of this benefit, the word 'permanent' shall mean beyond the hope of recovery with current medical knowledge and technology.

Liver disease secondary to alcohol or drug abuse are excluded

C14 Surgery of Aorta

The actual undergoing of surgery (including key-hole type) for an illness or injury of the aorta needing excision and surgical replacement of diseased part of the aorta with a graft.
The term 'aorta' means the thoracic and abdominal aorta but not its branches.
Stent - grafting is excluded.

C15 Major Burns

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a Consultant Physician.

Burns arising due to self infliction are excluded.

C16 Loss of Speech

It means total and irrecoverable loss of the ability to speak as a result of injury or disease to the Vocal Cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist and supported by our Company Doctor.
All psychiatric related causes are excluded.

C17 Deafness

It means total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by audiometric and sound threshold tests provided and certified by an Ear, Nose, Throat (ENT) specialist and supported by the Company Doctor.

Total means "the loss of at least 80 decibels in all frequencies of hearing" in both ears.

C18 Coma of specified severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs.
This diagnosis must be supported by evidence of all of the following:

1. No response to external stimuli continuously for at least 96 hours;
2. Life support measures are necessary to sustain life; and
3. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
4. The condition has to be confirmed by a specialist medical practitioner.

Coma resulting directly from alcohol or drug abuse is excluded.

10. **Day Care Procedure cash (DCP):** In case of hospitalization of the Insured/Insured Person/s for a medically necessary treatment as an inpatient for less than 24 hours in a Hospital or standalone day care centre for any of the below listed Procedures, then We will pay Day care Procedure Cash as mentioned in the Schedule to this Policy, for each procedure undertaken subject to the maximum of Yearly Sum Insured for that Policy year.

Covered Day Care Procedures:

1	Cataract
2	Dilatation and Curettage
3	Lithotripsy
4	Manipulation for Dislocation under General Anesthesia
5	Cystoscopy

11. **Wellness Program:**
The below services will be available when the Insured/Insured member/s is/are more than 150 kilometers within Indian territory from their residential address as provided in the Proposal Form. The services would be provided by Us / through our appointed Service provider, with prior intimation and acceptance by the Company.

i. **Medical Consultation, Evaluation and Referral:** In case of any emergency situation, We/our Service Provider will evaluate, troubleshoot and make immediate recommendations including referrals to qualified doctors and/or hospitals.

ii. **Medical Monitoring and Case Management:** A team of doctors, nurses, and other medically trained personnel would be in regular communication with the attending physician and hospital, monitors appropriate levels of care and relay necessary and legally permissible information to the members of the Family / employer.

iii. **Emergency Medical Evacuation:** If the Insured / Insured member/s becomes ill or injured in an area where appropriate care is not available, the Company / via Service Provider will intervene and use available transportation, equipment and personnel necessary to evacuate the Individual safely to the nearest facility for medical care.

iv. **Compassionate Visit:** When an Insured Peron/s is/are hospitalized for more than seven (7) consecutive days, The Company/ Service Provider will arrange for a family member or a personal friend to travel to visit the Insured Person/s, by providing an appropriate means of transportation

12. **Special Care:** You can opt this cover and get a fully recharged Policy without any Duration limits as specified under Schedule of Benefits attached to this document. This option is available only if You are below 65 years of age

13. **Special Limits:** You can opt for this cover and select lower Daily Hospital Cash (DHC) Benefit than as eligible as per the Schedule of Benefits attached to this document. The minimum DHC limit can be 0.5% of Sum Insured.

C. Exclusions

1. **Waiting Period Exclusions:**
   a. **30 days Waiting Period Exclusion:**
   A waiting period of 30 days from the commencement date of the first Policy will apply to all disease/ illness contracted other than accidental bodily injury requiring hospitalization.
   b. **90 days Waiting Period Exclusion:** A waiting period of 90 days from the commencement date of the first Policy will apply to Critical Illness(es) contracted requiring Hospitalization.
   c. **First Year Waiting Period Exclusion:**
   During the first year of operation of this insurance cover, expenses on treatment of the following diseases are not payable: Cataract, Benign Prostatic Hypertrophy, Hernia, Hydrocele, Fistula in anus, piles, Sinusitis and related disorders, Fissure, Gastric and Duodenal ulcers, gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus, polycystic ovarian diseases; skin tumors unless malignant, benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); & Congenital Internal Diseases.
   d. **Two Year Waiting Period Exclusion:**
   During the first two years of the operation of this insurance cover, the expenses on treatment of following diseases are not payable: Calculus diseases of Gall bladder and Urogenital system, Hypertension and Diabetes and related complications, Joint Replacement due to Degenerative condition, Surgery for prolapsed inter vertebral disc unless arising from accident, Age related Osteoarthritis and Osteoporosis, Spondylosis / Spondylitis, Surgery of varicose veins and varicose ulcers.
   Diabetes & related complications including but not limited to: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hypo/Hyperglycemic Shocks.
   Hypertension & related complications including but not limited to: Coronory Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal Bleed/Haemorrhages. If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing, then Pre-Existing Condition Exclusion (1.e below) shall be applicable.
   e. **Pre- Existing Condition Exclusion:**
   Pre-existing Conditions and any complications arising from the same will not be covered until 36 months of continuous coverage have elapsed, since inception of your first Policy with Us.

2. We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary elsewhere in this Policy:
   1. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice & Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T Cell Lymphotropic Virus Type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
   2. Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy.
   3. Any treatment arising from or traceable to any fertility, infertility, sub fertility or assisted conception procedure or sterilization, birth control procedures, hormone replacement therapy, contraceptive supplies, or services including complications arising due to supplying services or Assisted Reproductive Technology.
   4. Any dental treatment or surgery unless requiring hospitalization arising out of an accident.

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5. 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.
6. Experimental, investigational or unproven treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or consequence of undergoing such experimental or unproven treatment.
7. Any weight management services, procedures and treatment, services and supplies including those related to treatment of conditions and complication arising out of obesity (including morbid obesity)
8. Any procedure, investigation, treatment related to sleep disorder or sleep apnea syndrome, general debility, convalescence, cure, rest cure, health hydros, nature cure clinics, sanatorium treatment, rehabilitation measures, private duty nursing (unless covered under the Policy), respite care, long term nursing care, custodial care or any treatment in an establishment that is not a Hospital.
9. External Congenital Anomaly.
10. Treatment of mental illness, stress, psychiatric or psychological disorders.
11. Aesthetic treatment, cosmetic surgery/implants or plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury or Burns.
12. Any treatment / surgery for change of sex or gender reassignments including any complication arising from these treatments.
13. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident
14. Alternative treatment
15. Any OPD treatment
16. Treatment received outside India
17. Charges incurred at Hospital Primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury for which Inpatient Care/Day Care Treatment is required
18. 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.
19. Any Illness or Injury arising from Insured Person committing any breach of law with criminal intent.
20. 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.
21. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.
22. Stem Cell implantation, harvesting, storage or any kind of treatment using stem cells
23. Any Hospitalisation primarily for investigation and / or diagnosis purpose.
24. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
    a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
    b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
    c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death

    In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded.
25. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants
26. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products
27. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institutions
28. EECP & Chelation Therapy, Rotational Field Quantum Magnetic Resonance (RFQMR) or Cytotron therapy.
29. Any treatment/loss required arising from Insured Person's participation in any hazardous activity including but not limited to scuba diving, hang-gliding, engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parachuting, hang gliding, rock or mountain climbing, winter sports, mountaineering (where ropes or guides are customarily used), caving or potholing, hunting or equestrian, sky diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), polo, snow and ice sports, professional sports or any other potentially dangerous sport.

D. Claim Procedure

A) Notification and Submission of Claim:

Upon the happening of any event giving rise or likely to give rise to a claim under this Policy, a notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of Illness/Injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us immediately or not later than 7 days from the date of hospitalization/Injury/death.

Please ensure to send the claim form duly completed in all respects along with all the following documents within 15 days from the date of discharge from Hospital.

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) Documentation:

a. You shall deliver to Us, within 15 days from the date of discharge a detailed statement in writing as per the claim form together with bills, vouchers and any other material particular, relevant to the making of such claim.
b. We may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond your control.

C) Payment of Claim:

a. We shall be under no obligation to make any payment under this Policy unless We have received all the premium payments in full and all payments have been realised and We have been provided with the documentation and information We have requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy
b. This Policy only covers medical treatment taken in India, and payments under this Policy shall only be made in Indian Rupees within India
c. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could reasonably have minimised the costs incurred, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner

The Claim Procedure would be in full compliance with relevant provisions of Insurance Regulatory and Development Authority Health Regulation 2013.

For further details/checklist for claims documents, please read the Policy or Claims Manual.

Indicative 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.
- ☐ Attested copy of Detailed Discharge Summary / Day care summary from the hospital.
- ☐ Attested copy of consolidated hospital bill with bill no and break up of each Item, duly signed by the insured.
- ☐ Attested copy of payment Receipt of the hospital bill with receipt number.
- ☐ First Consultation letter and subsequent Prescriptions.
- ☐ Attested copy of 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
- ☐ Attested copy of medicine bills and receipts with corresponding Prescriptions.
- ☐ Attested copy of invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.

Road Traffic Accident

In addition to the In-patient Treatment documents:

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

In Non-Medico legal cases

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

In Accidental Death cases

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

For Death Cases

In addition to the In-patient Treatment documents:

- ☐ Attested copy of Death Summary from the hospital.
- ☐ Attested copy of the Death certificate from treating doctor or the hospital authority.
- ☐ Attested copy of the Legal heir certificate, if the claim is for the death of the principle insured.

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

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Applicable to all claims under the Policy:

- In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, We shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.
- The Insured Person must give Us at his expense, all the information We ask for about the claim and he must help Us to take legal action against anyone if required.
- We are entitled to verify medical records of the case retained by the Hospital as and when required for verification of claim.
- If required, the Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense.
- If required, the Insured person must agree to be examined by a medical practitioner of our choice at Our expenses.
- The Policy would generally exclude the Standard List of excluded items as may be stipulated by the Authority from time to time unless otherwise agreed upon by the Company and specified so in the Policy document.
- We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days of submission of all necessary documents / information and any other additional information required for the settlement of the claim. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDA (Protection of Policyholders Regulation), 2002. 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 IRDA (Protection of Policyholders Regulation), 2002, 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' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.
- In an event claim event falls within two Policy Period, then we shall settle claim by taking into consideration the available Sum Insured and applicable deductible in the two Policy Periods. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the renewal /due date of the premium of health insurance policy, if not received earlier.

E. Discount / Loading Parameters

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

<table>
<tr><th>Sr. No.</th><th>Discount</th><th>Fresh Policy</th><th>Renewal Policy</th></tr>
<tr><td>1</td><td>Family Discount:

Family cover on Individual Sum Insured basis: Avail a maximum discount of upto10% discount on applicable premium,by covering family members under a single policy. This discount is available on fresh as well as on renewal of the Policy subject to family member being covered on Individual Sum Insured basis.

<table>
<tr><th>No. of members covered under a Policy</th><th>Family Discount (expressed as a % of total payable premium for all lives covered in a Policy)</th></tr>
<tr><td>2</td><td>5%</td></tr>
<tr><td>3</td><td>7.5%</td></tr>
<tr><td>4 and above</td><td>10%</td></tr>
</table></td><td>✓</td><td>✓</td></tr>
<tr><td>2</td><td>Employee Discount: 10% discount on the applicable premium for employees on the roll of the Company as on the date of commencement of Policy/ renewal of Policy.</td><td>✓</td><td>✓</td></tr>
<tr><td>3</td><td>Loyalty Discount: You are eligible for 5% discount on the applicable premium if you have Our any other retail health insurance Policy as on date of the commencement of this Policy/renewal of this Policy.</td><td>✓</td><td>✓</td></tr>
<tr><td>4</td><td>Long Term Policy Discount: Applicable when the policy term opted is beyond one year.

<table>
<tr><th>Policy Term</th><th>Discount</th></tr>
<tr><td>2 Years</td><td>7.5%</td></tr>
<tr><td>3Years</td><td>10%</td></tr>
</table></td><td>✓</td><td>✓</td></tr>
<tr><td>5</td><td>Direct Policy Purchase Discount: 10% discount will be given if you are purchasing this Policy through Our Website / direct channels.</td><td>✓</td><td>✓</td></tr>
<tr><th>Sr. No.</th><th>Loading</th><th>Fresh Policy</th><th>Renewal Policy</th></tr>
<tr><td></td><td>Proposals where the Health status of the Insured is adverse, as revealed in the Proposal form may be accepted at the sole discretion of the Company with an increased risk rating which shall not exceed 100% of normal slab premium per diagnosis / medical condition and not over 200% of normal slab premium per person. Applicable for all subsequent renewal(s) involving age slab changes and increase in Sum Insured.In all such cases, we would send a communication letter to the Proposer and obtain his/her consent before acceptance of the Proposal.

The following major factors are illustrative of the methodology to be followed for Sub-standard risks where premium rating will be done based on the medical condition and the health status of the applicant:

<table>
<tr><th>Sr. No</th><th>PED</th><th><40 yrs</th><th>>41 yrs and <55 yrs</th><th>>56 yrs</th></tr>
<tr><td>1.</td><td>Hypertension without its complications</td><td>10% on the Normal slab premium.</td><td>15% on the Normal slab premium.</td><td>Decline</td></tr>
<tr><td>2.</td><td>Diabetes without its complications</td><td>20% on the Normal slab premium.</td><td>20% on the Normal slab premium</td><td>Decline</td></tr>
<tr><td>3.</td><td>Asthma/ Chronic Obstructive respiratory Disease</td><td>10% on the Normal slab premium</td><td>15% on the Normal slab premium</td><td>20% on the Normal slab premium</td></tr>
</table></td><td>✓</td><td></td></tr>
</table>

F. General Terms And Conditions

1. **Disclosure of Information Norm**
The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of mis - representation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or device being used by the Insured/ Insured Person/s or any one acting on his/their behalf to obtain a benefit under this Policy.

2. **Reasonable Care**
The Insured shall take all reasonable steps to safeguard the interests of the Insured against accidental loss or damage that may give rise to the claim.

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

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

5. **Material Change**
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.

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6. Records to be maintained

The Insured Person/s shall keep an accurate record containing all relevant medical records and shall allow the Company to inspect such record. The Insured Person/s shall furnish such information to the Company as may be required under this Policy at any time during the Policy Period or until the final adjustment, if any and resolution of all Claims under this Policy.

7. Notice of charge

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

8. Fraudulent Claims

If any claim 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/Insured Person/s or any one acting on his / her behalf to obtain any benefit under this Policy, or if a claim is made and rejected and no Court action or suit is commenced within twelve months after such rejection all benefits under this Policy shall be forfeited.

9. Renewal

The Policy shall ordinarily be renewable except on the grounds of fraud, moral hazard or misrepresentation or non-cooperation by the Insured. Policy will automatically terminate at the end of the Policy Period. However Grace Period of 30 days for renewing the Policy is provided under this Policy. Any claim/loss during the grace period will not be covered.

We are under no obligation to give notice that it is due for renewal or to renew it on the same terms whether as to premium or otherwise. All Renewal applications and requisite premium shall be given to us on or before the Policy Period end date and in any event before the expiry of the Grace Period.

The Insured shall give the Company written notice along with Renewal Application, of any material changes to the risk insured under the Policy. If no such written notice is received by us along with renewal application it shall be deemed that there is no material change to the risk. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company.

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

Insured Person/s could avail of policy renewal in terms of the applicable portability norms governing such renewals and the same would be renewed in accordance with the Company's underwriting policy.

We are not under any obligation to Renew your Policy on same terms or premium as the expiring Policy. Any change in benefit or premium (other than due to change in Age) will be done with the approval of the IRDA and will be intimated to You atleast 3 months in advance. In the likelihood of this policy being withdrawn in future, we will intimate you about the same 3 months prior to policy expiry.

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

Sr. No	No. of years of continuous insurance cover with previous insurer(s)	Waiting period to be served with new insurer in number of days/years upon Portability					
		30 days	90 days	1 Year	2 Year	3 Year	4 Year
1	1 Year	NIL	NIL	NIL	1 Yr	2 Yr	3 Yr
2	2 years	NIL	NIL	NIL	NIL	1 Yr	2 Yr
3	3 years	NIL	NIL	NIL	NIL	NIL	1 Yr
4	4 years	NIL	NIL	NIL	NIL	NIL	NIL

10. Entry Age

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

Child/children below 18 years of age can be covered provided either of the parents is insured under the policy. The child/ children above 18 years of age can continue to be covered under the policy.

11. Sum Insured Enhancement

For Hospi-Cash Connect plans, the 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 Sum Insured, waiting period will apply afresh in relation to the amount by which the Sum Insured has been enhanced.

12. Sub-standard Risk

Proposals where the Health status is adverse, as revealed in the proposal form and/or followed by health check-up may be accepted at the sole discretion of the Company with an increased risk rating which shall not exceed 100% of normal slab premium per diagnosis / medical condition and not over 200% of normal slab premium per person. Applicable for all subsequent renewal(s) involving age slab changes and increase in Sum Insured.

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

13. Health Check-up

The health check-up will be carried out 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. If the proposal is accepted we shall refund 50% of the health check-up cost

14. Cancellation/Termination

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

Cancellation by Insurer:

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. The Company may, in the event of non-cooperation of the Insured/Insured person/s cancel this Policy, by giving 15 days' notice in writing by Registered Post Acknowledgment due to the Insured/ Insured Person/s at his / their last known address in which case the Company shall be liable to repay a rateable proportion of the premium for the unexpired term from the date of the cancellation subject to there being no claim made/ reported under the Policy.

Cancellation by Insured/Insured Person:

The Insured may elect to cancel the Policy by giving 15 days' notice in writing to the Company. If no claim has been made under the Policy then the Company shall from the date of receipt of notice cancel the Policy and shall refund the premium as per the Table below;

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

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

15. Withdrawal of Product

In case the product is found to be financially unviable or is deficient in any manner, the Company shall, in terms of Insurance Regulatory & Development Authority (Health Insurance) Regulations 2013, have the option to withdraw this product from the market subject to prior approval of such withdrawal from the Regulatory Authority. Any withdrawal of the product would be duly intimated to existing customers, who on expiry of the existing Policy, will have an option to obtain renewal under similar product/s available with Us. The Company shall allow the benefit of Portability in all such cases.

16. Free Look Cancellation

A period of 15 days from the date of receipt of Policy document is available to review the terms, conditions and exclusions of the Policy. The Insured has the option of cancelling the Policy stating the reasons for cancellation if he has any objections to any of the terms, conditions and exclusions. The company shall refund the premium paid after adjusting the amounts spent on medical examination of the Insured person/s, Stamp Duty Charges and proportionate risk premium in case the risk has already commenced. Cancellation will be allowed only if there are no claims reported under the Policy. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. Free look provision is available only at the time of inception of the first Policy contract with us and not at the time of renewal of the Policy.

17. Continuity Benefits

Portability: If You are insured continuously and without interruption under any other similar health insurance policy issued by Indian General and/ or Standalone Health Insurer's individual insurance policy and you want to shift

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to us on renewal, the Company will consider such requests on proper evaluation allowed in terms of the Portability Guidelines issued by IRDA.
Also, if you are insured continuously and without interruption under our similar Health Insurance Policy, and you want to shift to this policy on individual or family cover, the Company will consider such requests on proper evaluation, as per Portability Guidelines issued by IRDA.

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

19. Area of Validity
The Policy shall provide for eligible medical treatment taken within India & all the benefits under the Policy shall be payable in Indian rupees only.

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

21. Arbitration
If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no dispute or difference shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a Condition Precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

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

23. 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.

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

In case of Insured:
As mentioned in the schedule

In case of the Company:
Liberty General Insurance Ltd.
10th Floor, Tower A, Peninsula Business Park,
Ganpatrao Kadam Marg,
Lower Parel, Mumbai – 400013
Tel: 02207001313
Fax : 022 67001606
Notice and instruction will be deemed served 7 days after posting or immediately upon recipient in the case of hand delivery, fax or e-mail.

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

G. Grievance Redressal Procedure

We assure the best customer service from our end to our valued Insured/Insured Person(s) and request you to adopt following procedure in case of any service related query or grievance.

You may communicate your query or grievances by sending a letter to below mentioned address or to your nearest branch or email at below mentioned email ID or by calling at our below mentioned call center number.

Customer Care Cell

Liberty General Insurance Limited
10th Floor, Tower A, Peninsula Business Park, Lower Parel, Mumbai
E-mail : care@libertyinsurance.in
Toll Free No. 1800 266 5844
Please include your Policy number in all your communication with the Company. This will help us resolve the issue more efficiently.

The Company had a separate channel to address the grievances of Senior Citizens insured/ insured person(s)

If You are not satisfied with redressal of Your grievance, You may approach the nearest Insurance Ombudsman for resolution of Your grievance. The contact details of the Ombudsman offices are mentioned below;

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
Ahmedabad	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, Ahmedabad-380 014. Tel.: 079-27546840 Fax : 079-27546142 Email ins.omb@rediffmail.com	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
Bhopal	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, Bhopal (M.P.) - 462 023. Tel.: 0755-2569201 Fax : 0755-2769203 Email bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
Bhubaneshwar	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar-751 009. Tel.: 0674-2596455 Fax : 0674-2596429 Email ioobbsr@dataone.in	Orissa
Chandigarh	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel.: 0172-2706468 Fax : 0172-2708274 Email ombchd@yahoo.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
Chennai	Insurance Ombudsman, Office of the Insurance Ombudsman, FathimaAkhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, Chennai-600 018. Tel.: 044-24333668 /5284 Fax : 044-24333664 Email insombud@md4.vsnl.net.in	Tamil Nadu, UT-Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
New Delhi	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, New Delhi-110 002. Tel.:- 011-23239633 Fax : 011-23230858 Email iobdelraj@rediffmail.com	Delhi & Rajasthan
Guwahati	Insurance Ombudsman, Office of the Insurance Ombudsman, "JeevanNivesh", 5th Floor, Near Panbazar Overbridge, S. S. Road, Guwahatl-781 001 (ASSAM). Tel.:- 0361-2132204/5 Fax : 0361-2732937. Email ombudsmanghy@rediffmail.com	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura

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Hyderabad	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel : 040-65504123 Fax : 040-23376599, Email insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
Ernakulam	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, Ernakulam-682 015. Tel : 0484-2358759 Fax : 0484-2359336. Email iokochi@asianetindia.com	Kerala, UT of (a) Lakshadweep , (b) Mahe – a part of UT of Pondicherry
Kolkata	Insurance Ombudsman, Office of the Insurance Ombudsman, North British Bldg., 29, N.S. Road, 4th Floor, Kolkata-700 001. Tel : 033-22134866 Fax : 033-22134868. Email iombkol@vsnl.net	West Bengal, Bihar, Jharkhand and UT of Andeman& Nicobar Islands, Sikkim
Lucknow	Insurance Ombudsman, Office of the Insurance Ombudsman, JeevanBhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, Lucknow-226 001. Tel : 0522 -2231331 Fax : 0522-2231310 Email insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
Mumbai	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S.V. Road, Santacruz(W), Mumbai-400 054. Tel : 022-26106928 Fax : 022-26106052 Email ombudsmanmumbai@gmail.com	Maharashtra, Goa

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.

H. Benefit Schedule

Hospi-Cash Connect : The Sum insured options and covers provided below are fixed and may be selected as per the Plans given below.

Plan	SI p.a. (INR)	Daily Hospital Cash Benefit (DHC) (INR/day) OR Daily Hospital Cash - Only Accident Benefit (INR/day)	Double Accident Benefit - in case of Hospitalization more than 3 days (INR/day)	Double ICU Benefit - Sickness (INR/day)	Double ICU Benefit - Accident (INR/day)	Recovery Benefit	Sp. Care on Minor Surgeries Threshold Limit of INR 50000	Sp. Care on Major Surgeries Threshold Limit of INR 200000	Restore Benefit
Hospi Sure	**2 L**	2000	4000	4000	4000				
	3 L	3000	6000	6000	6000				
	4 L	4000	8000	8000	8000				
	5 L	5000	10000	10000	10000				
	7.5 L	7500	15000	15000	15000				
	10 L	10000	20000	20000	20000				
Hospi Sure Optima	**2 L**	2000	4000	4000	4000	**5 times of DHC**			
	3 L	3000	6000	6000	6000				
	4 L	4000	8000	8000	8000				
	5 L	5000	10000	10000	10000				
	7.5 L	7500	15000	15000	15000				
	10 L	10000	20000	20000	20000				
Hospi Sure Ultima	**2 L**	2000	4000	4000	4000	**5 times of DHC**	**3 times of DHC**		
	3 L	3000	6000	6000	6000				
	4 L	4000	8000	8000	8000				
	5 L	5000	10000	10000	10000				
	7.5 L	7500	15000	15000	15000				
	10 L	10000	20000	20000	20000				
Hospi Sure Supreme	**2 L**	2000	4000	4000	4000	**5 times of DHC**	**3 times of DHC**	**5 times of DHC**	
	3 L	3000	6000	6000	6000				
	4 L	4000	8000	8000	8000				
	5 L	5000	10000	10000	10000				
	7.5 L	7500	15000	15000	15000				
	10 L	10000	20000	20000	20000				
Hospi Sure Excel	**2 L**	2000	4000	4000	4000	**5 times of DHC**	**3 times of DHC**	**5 times of DHC**	**Equivalent to SI**
	3 L	3000	6000	6000	6000				
	4 L	4000	8000	8000	8000				
	5 L	5000	10000	10000	10000				
	7.5 L	7500	15000	15000	15000				
	10 L	10000	20000	20000	20000				
Duration Limits (applicable for all plans)		Per event/ Hospitalization limit - Upto 30 days	Per event/ Hospitalization limit - Upto 30 days	Per event/ Hospitalization limit - Upto 30 days	Per event/ Hospitalization limit - Upto 30 days				Restore SI once per Policy Year

Wellness Program Available on optional basis and serviced by Us / Through Our Service Provider

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Hospi Cash Connect Flexi			
	Sum Insured per annum (INR)	**Range for selection: INR 10,000 to INR 15,00,000 (in multiples of '00)**	**Duration Limits**
A.	**Basic Cover: Mandatory Cover**		
	Daily Hospital Cash (DHC) Benefit (INR/day)	1% of SI	Per event / Hospitalization limit - Upto 30 days
OR	Daily Hospital Cash (DHC) - Only Accidents Benefit (INR/day)	1% of SI	Per event / Hospitalization limit - Upto 30 days
B.	**Flexi - Choose and Pick Covers: Optional Cover**		
1	Double Accident Benefit (DAB) - in case of Hospitalization more than 3 days	Double the DHC limit	Per event / Hospitalization limit - Upto 30 days
2	Double ICU Benefit (DIB) - Sickness	Double the DHC limit	Per event / Hospitalization limit - Upto 30 days
3	Double ICU Benefit (DIB) - Accident	Double the DHC limit	Per event / Hospitalization limit - Upto 30 days
4	Double Critical Illness Benefit (DCI) - Listed Critical Illnesses	Double the DHC limit	Per event / Hospitalization limit - Upto 30 days
5	Day Care Procedure Cash - Listed Procedures	50% of DHC Limit	Max upto 5 Day Care Procedures
6	Recovery Benefit	Up to 15 times of DHC limit	
7	Convalescence Benefit	Up to 15 times of DHC limit	
8	Special Care on Minor Surgeries Threshold Limit Applicable of INR 50000	Up to 15 times of DHC limit	
9	Special Care on Major Surgeries Threshold Limit Applicable of INR 200000	Up to 15 times of DHC limit	
10	Restore Benefit	Equivalent to the Sum Insured	
11	Wellness Program	Available and serviced by Us / Through Our Service Provider	
12	**Special Limit**	Option to select lower DHC limit	
13	**Special Care**	Policy without any Duration limits (Available for the member upto 65 years of age)	

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