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

LIBERTY'S HOSPI-CASH CONNECT POLICY

A. POLICY SCHEDULE

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

B. PREAMBLE

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

C. DEFINITIONS

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

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

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

2. **"Any One Illness"** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital/nursing home where treatment was taken.

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

   a. Central or State Government AYUSH Hospital; or

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

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

i. Having at least 5 in-patient beds;

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

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

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

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

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

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

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

5. **"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 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

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

   a) undertaken under General or Local Anesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and

   b) which would have otherwise required hospitalization of more than twenty four hours.

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

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

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. "**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.

12. **"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. **"Hospital"** means any institution established for in- patient care and day care treatment of disease / injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

    a) has qualified nursing staff under its employment round the clock;
    b) has at least ten inpatient beds in towns having a population of less than ten lakhs and at least fifteen in-patient beds in all other places;
    c) has qualified medical practitioner (s) in charge round the clock;
    d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e) maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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

14. **"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- means 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-means a disease, illness or injury that has one or more of the following characteristics:

a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
b) it needs ongoing or long-term control or relief of symptoms
c) it requires rehabilitations for the patient to be special trained to cope with it
d) it continues indefinitely
e) it recurs or is likely to recur

15. "**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.

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

17. "Intensive Care Unit (ICU)" 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.

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

19. "Maternity expense" 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.

20. "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.

21. "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.

22. "Medically Necessary treatment" means 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.

23. "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.

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

25. "Notification of Claim" is the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

26. "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.

27. "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.

28. "Pre-existing Disease" 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

b) 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.

29. "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.

30. "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.

31. "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.

1

32. "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.

33. "Sum Insured" means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

34. **"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.

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

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

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

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

3. **"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.

4. **"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..

5. **"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.

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

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

8. "**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.

9. **"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.

10. **"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.

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

12. **"Policy year"** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years,

policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

13. "**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.

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

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

16. **"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' (B2.6 of this document) and 'Special Care on listed Major Surgery' (B2.7 of this document).

D. BENEFITS COVERED UNDER THE POLICY

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 (including AYUSH 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 upto 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.

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

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 Section B1 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.
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

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:** 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 more than 15 consecutive days of hospitalization then a onetime 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/s 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 Rs 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 Rs 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 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 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.
7	Knee replacement (traumatic / septic arthritis, severe irreparable knee injury)
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/ Coronary Artery Bypass Surgery
C7	Stroke resulting in permanent symptoms

C8	Permanent Paralysis of Limbs
C9	Myocardial Infarction (First Heart Attack) of specified Severity
C10	Benign Brain Tumor
C11	Parkinson's Disease
C12	Alzheimer's Disease
C13	End Stage Liver Failure
C14	Surgery to Aorta/ Aorta Graft surery
C15	Third-Degree Burns (Major Burns)
C16	Loss of Speech
C17	Deafness
C18	Coma of specified severity

C1- Cancer of specified severity

- A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma
- The following are excluded –
  i) All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
  ii) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
  iii) Malignant melanoma that has not caused invasion beyond the epidermis;
  iv) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
  v) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
  vi) Chronic lymphocytic leukemia less than RAI stage 3
  vii) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
  viii) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
  ix) All tumors in the presence of HIV infection

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 (haemodialysis 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 unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
  i) investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
  ii) there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
- 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:
  i) One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
  ii) 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:
  i) Other stem-cell transplants
  ii) Where only islets of langerhans are transplanted

C5- Open Heart Valve Replacement/Repair of Heart Valves

- The actual undergoing of open-heart valve surgery is 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)/ Coronary Artery Bypass Surgery

- The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- The following are excluded:
  i) Angioplasty and/or any other intra-arterial procedures.

C7- Stroke resulting in permanent symptoms

- Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial 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 at least 3 months has to be produced.
- The following are excluded:
  i) Transient ischemic attacks (TIA)
  ii) Traumatic injury of the brain
  iii) 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- Myocardial Infarction (First Heart Attack of specified Severity)

- The first occurrence of heart attack or 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 Myocardial Infarction should be evidenced by all of the following criteria:
  i) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii) New characteristic electrocardiogram changes
iii) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

- The following are excluded:
  i) Other acute Coronary Syndromes
  ii) Any type of angina pectoris
  iii) A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

C10- Benign Brain Tumor

- Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
- This brain tumor must result in at least one of the following and must be confirmed by the Neurologist.
  i) Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
  ii) Undergone surgical resection or radiation therapy to treat the brain tumor.
- The following conditions are excluded:
  - Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

C11- 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.

C12- Alzheimer's Disease

- Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes.
- 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).
- 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.
- These conditions must be medically documented for at least 90 days.

The following conditions are however not covered:

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

C13- End Stage Liver Failure

- Permanent and irreversible failure of liver function that has resulted in all three of the following:
  i) Permanent jaundice; and
  ii) Ascites; and

iii) Hepatic encephalopathy.

- Liver failure secondary to drug or alcohol abuse is excluded.

C14- Surgery to Aorta/ Aorta Graft Surgery

- The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. Undergoing of a laporotomy or thoracotomy to repair or correct an aneurysm, narrowing, obstruction or dissection of the aortic artery.
- For the purpose of this definition, aorta means the thoracic and abdominal aorta but not its branches.
- Surgery performed using only minimally invasive or intra-arterial techniques such as percutaneous endovascular aneurysm repair are excluded. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures are excluded.

C15- Third-Degree Burns (Major Burns)

- There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

C16- Loss of Speech

- 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.
- All psychiatric related causes are excluded.

C17- Deafness

- Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across 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:
  i) No response to external stimuli continuously for at least 96 hours;
  ii) Life support measures are necessary to sustain life; and
  iii) Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
- The condition has to be confirmed by a specialist medical practitioner
- Coma resulting 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.

E. EXCLUSIONS

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

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

1. Pre- Existing Diseases – Code –Excl01

a. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded as per the Plan mentioned in the Policy schedule i.e.until the expiry of 36 months of continuous coverage after the date of inception of the first policy with Us.

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If the Insured person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to be extent of prior coverage.
d. Coverage under the policy after the expiry of applicable months as per the Plan, for any Pre-exiting Disease is subject to the same being declared at the time of application and accepted by the Insurer.

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

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

Sr. No	First Year (12 months) Waiting Period	Two Year (24 months) Waiting Period
1.	Cataract	Calculus diseases of Gall bladder and Urogenital system
2.	Benign Prostatic Hypertrophy	Joint Replacement due to Degenerative condition,
3.	Hernia	Surgery for prolapsed inter vertebral disc unless arising from accident
4.	Hydrocele	Age related Osteoarthritis and Osteoporosis
5.	Fistula in anus	Spondylosis / Spondylitis
6.	Piles	Surgery of varicose veins and varicose ulcers.
7.	Sinusitis and related disorders	Diabetes & related complications: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hypo/Hyperglycemic Shocks
8.	Fissure	Hypertension & related complications: Coronory Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal bleed/Haemorrhages.
9.	Gastric and Duodenal ulcers	Treatment for correction of eye sight (laser surgery) due to refractive error
10.	Gout and Rheumatism	*Treatment related to Anxiety (F06,F40-41), Conduct &

		Mood disorders (F34,F38-39,F92-93,F98), Personality disorders (F60-61,F93) and stress (F43) F04, F07, F09 (Organic, including symptomatic, mental disorders)
11.	Internal tumors, cysts, nodules, polyps , breast lumps (unless malignant)	
12.	Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus	
13.	Polycystic ovarian diseases	
14.	Skin tumors (unless malignant)	
15.	Benign ear, nose and throat (ENT) disorders and surgeries, adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty	
16.	Dilatation and Curettage (D&C);	
17.	Congenital Internal Diseases	

3. 30-day waiting period- Code- Excl03

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

4. Investigation & Evaluation – Code-Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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

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

6. Obesity/ Weight Control: Code- Excl06

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

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

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

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

8. Cosmetic or plastic Surgery: Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

9. Hazardous or Adventure sports: Code- Excl09

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

10. Breach of law: Code- Excl 10

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

11. Excluded Providers : Code-Excl11

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

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

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

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

15. **Refractive error: Code – Excl15**

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

16. **Unproven Treatments: Code- Excl16**

    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. **Birth control, Sterility and Infertility: Code- Excl17**

    Expenses related to Birth Control, sterility and infertility. This includes:

    (i) Any type of contraception, sterilization
    (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    (iii) Gestational Surrogacy
    (iv) Reversal of sterilization

18. **Maternity: Code Excl18**

    ii. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    iii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

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

1. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice & Trichomoniasis, Human T Cell Lymphotropic Virus Type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

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

3. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

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

5. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.P.A.D) and oxygen concentrator or asthmatic condition, cost of cochlear implants.

6. External Congenital Anomaly.

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

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

9. Treatment received outside India

10. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, mutiny, military or usurped acts, seizure, capture, arrest, restraints and detainment of all kinds.

11. Act of self-destruction or self-inflicted, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens.

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

13. Personal comfort and convenience items or services including but not limited to TV(wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs, (except patient's diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

14. 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.

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

16. **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.

17.

F. GENERAL TERMS AND CONDITIONS

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

a. Disclosure of information

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

b. Condition Precedent to admission of Liability

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

c. Claim Settlement (Provision for Penal Interest)

a. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
d. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Explanation: "Bank Rate" shall mean the rate fixed by Reserve Bank of Indian (RBI) at the beginning of the financial year in which the claim has fallen due.

d. Complete Discharge

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

e. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

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

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

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

f. Cancellation/Termination

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

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

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

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

(ii) The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Cancellation Grid	Time period	Claim Status	One Year - Single payment /Instalment policy	2/3 Years Policy tenure -Single payment /Instalment policy
Free Look Period (Risk not commenced)	Upto30 days	Nil	Full refund less medical examination of insured person and the stamp duty charges	
Free Look Period (Risk commenced)	Upto30 days	Nil	Proportionate refund for unexpired policy period	
Pro rate (Risk commenced)	Beyond 30 days	Nil	Proportionate refund for unexpired policy period	

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

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.

g. Migration

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

h. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. lf such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an lndian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

F

i. 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 at least 30 days prior to expiry of the policy.

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

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

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

j. Withdrawal of Policy

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

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.

k. Moratorium Period

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

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

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

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

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

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

Sno	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 years	3 years	4 years
1	1 Year	NIL	NIL	NIL	1 Yr	2 Yr	2 Yr
2	2 years	NIL	NIL	NIL	NIL	1 Yr	1 Yr
3	3 years	NIL	NIL	NIL	NIL	NIL	NIL
4	4 years	NIL	NIL	NIL	NIL	NIL	NIL

n. 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;

o. 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	If our response or resolution does not meet your expectations, you can escalate at Manager@libertyinsurance.in

Email us at: care@libertyinsurance.in **Senior Citizens can email us at**: seniorcitizen@libertyinsurance.in or **Write to us at:** **Customer Service** **Liberty General Insurance Limited** 10th Floor, Tower A, Peninsula Business Park, Ganpatrao Kadam Marg, Lower Parel, Mumbai 400 013	**Step 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. The contact details of the Insurance Ombudsman offices have been provided in **Annexure B**:

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

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

p. Nomination

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

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

1. Observance of Terms and Conditions

The due observance and fulfillment of the terms, conditions and endorsements, including the payment of

premium of this Policy and compliance with specified claims procedure insofar as they relate to anything to be done or complied with by the Insured shall be a Condition Precedent to any liability of the Company to make any payment under this Policy.

2. Alterations to the Policy

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

3. Material Change

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

.

4. Records to be maintained

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

5. Notice of charge

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

6. Area of Validity

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

7. Policy Disputes

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

8. Arbitration

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

third arbitrator to be appointed by such two arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.
It is clearly agreed and understood that no dispute or difference shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a Condition Precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

9. Electronic Transaction

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

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

In case of Insured –

As mentioned in the schedule

In case of the Company:

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

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

G. OTHER TERMS AND CONDITIONS:

1. Entry Age

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

Child/children below 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.

2. 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.

3. 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.

4. 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

5. 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 upto 10% 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>
</table>

<table>
<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><td>Sr. no.</td><td>Loadings</td><td>Fresh Policy</td><td>Renewal Policy</td></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>

6. 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 Your beyond the 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

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

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 of the Death certificate from treating doctor or the hospital authority.
- ❑ Attested copy of 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.

Applicable to all claims under the Policy:

- In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, We shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.
- If required, the Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense.
- If required, the Insured person must agree to be examined by a medical practitioner of our choice at Our expenses.
- The Policy - excludes the Standard List of excluded items - attached in the Policy document.
- No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy
- Claim settlement (provision for Penal Provision)
    i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

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

    iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than

30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

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

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. (Rs)	Daily Hospital Cash Benefit (DHC) (Rs/day) OR Daily Hospital Cash- Only Accident Benefit (Rs/day)	Double Accident Benefit- in case of Hospitalization more than 3 days (Rs/day)	Double ICU Benefit- Sickness (Rs/day)	Double ICU Benefit- Accident (Rs/day)	Recovery Benefit	Sp. care on Minor Surgeries Threshold Limit of Rs. 50000	Sp. care on Major Surgeries Threshold Limit of Rs. 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									

		Hospi Cash Connect Flexi	
	Sum Insured per Annum (Rs.)	**Range for selection: Rs 10,000 to Rs. 15,00,000 (in multiples of '00)**	**Duration Limits**
A.	**Basic Cover: Mandatory Cover**		
	Daily Hospital Cash (DHC) Benefit(Rs./day)	1% of SI	Per event/Hospitalization limit- Upto 30 days
OR	Daily Hospital Cash (DHC)- Only Accidents Benefit(Rs./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	Up to 15 times of DHC limit	

	Threshold Limit Applicable of Rs. 50000		
9	Special care on Major Surgeries	Up to 15 times of DHC limit	
	Threshold Limit Applicable of Rs. 200000		
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)	

Annexure B- The contract details of the Insurance Ombudsman offices are as below:

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in

Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.l.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, BhagwanSahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in

Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth,Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in